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Mental Hospitals

Hospital Journal
of the American Psychiatric Association

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PRESIDENTIAL ADDRESS

By R. H. FELIX, M.D.

President, American Psychiatric Association

Director, National Institute of Mental Health, Bethesda, Maryland

The Hospital and the Community

THE EFFORTS of the professional associations, of various public agencies, and of the thousands of dedicated mental hospital workers represented by this audience have literally worked miracles in improving the treatment of the mentally ill. It is as a result of these improvements that the mental hospital now finds itself at the crossroads of change and new direction.

The advent of pharmacotherapy and the recent emphasis on social psychiatry have given a tremendous impetus to the treatment of the mentally ill in extramural situations, and to a virtual revolution in administrative and therapeutic programs within the hospital. New types of extramural facilities have been developed, and new patterns of cooperation between these facilities and community agencies are beginning to appear. The first reaction to the new therapeutic measures, the new day and night hospitals, and the new concepts of administrative psychiatry was a reaction against the big public mental hospital. The word went out from many quarters that the big mental hospital was a thing of the past, that it could not be adapted to the "new approach" in psychiatry, that it should be closed up and abandoned.

Now that we have lived with our new advances for a few years, I think we are able to make a calmer appraisal of the situation. A differentiation must be made between the large mental hospital and mental hospitals in general. I am in full agreement with Hamilton, Solomon, and others that the large hospital should be broken up into smaller hospitals. Institutions with more than 3,000 beds are too large. Those with more than 5,000 beds should be reduced in size as quickly as possible—by being broken up into separate segments, by discharge of certain classes of patients, or by whatever methods are necessary. The smaller public mental hospital of 3,000 beds or less is by no means bankrupt yet. Properly staffed and equipped, it is both essential and effective. Without a doubt it has unmet needs. It needs refurbishing; it needs reorganization; it needs to take a new look at itself, to take stock of its defects and its poten-

tialities, and to plan for the future. Particularly, the mental hospital must review its relationship with the community, and its responsibility to contribute its talents and abilities to the total community effort to help the mentally ill.

The need for cooperation between the community and the hospital is far from being a new concept. Such cooperation has been a fact for a long time in the case of some psychiatric hospitals, both public and private. In recent years more and more hospitals have contributed to this trend. In the past decade, as an increasing number of general hospitals have opened up or expanded psychiatric departments, new examples and new patterns of cooperative activity between extramural and intramural mental health facilities have emerged.

Many of the old walls are beginning to come down, but no one can deny that the mental hospital still has some distance to go to become the integral part of the community that it should be. Though walls are coming down, there are not enough clear paths between the community and the hospital. Those of us who are attempting to build up communications between the community and the hospital still have to thread our way through a confused rubble of old walls. Old practices, old misunderstandings, old prejudices still block our way. Some of us become engulfed by the very walls we help to crash down. Others find themselves the target of attacks by those who miss the familiar walls and "lay about them" with the debris of half-truths and misconceptions about mental illness.

The immediate task that confronts us is to clear away this debris, to build on the fine beginnings and pioneering paths to and from the hospital that we already have, and to plan and build broad highways of constructive interaction with the community—highways of communication not only for the hospital patient and staff but also for all of the citizens in the community. Though the task is immense, it is thoroughly feasible, and there are orderly and purposeful steps that we can take to accomplish our objective. These necessary measures fall into three major categories:

1. The development of a system of rational and effective links between the hospital and the community, which will make the paths leading to the mental hospital less complicated and formidable.

2. The development of effective and strong relationships with the family and the community while the patient is in the hospital.

3. The construction of an integrated set of social institutions surrounding the discharge of the patient from the hospital and his return to the community.

Despite the fact that between 125,000 and 150,000 people are admitted to public mental hospitals in the United States each year, up to recently there has been virtually no examination of the process by which patients find their way to the hospital. The only familiar part of this process was the crisis which precipitated hospitalization, followed by the court commitment procedure, with its confusion of legal and medical activities.

I do not believe that the present confusion in the paths to the mental hospital can be cleared away until some rather drastic legislative action is taken in many states. The American Bar Foundation is currently conducting a study of mental illness and the law—an extensive survey of commitment practices to permit evaluation of the adequacy of present laws and prepare the way for recommended model legislation. The project includes a study of voluntary commitments, and provision is being made for professional psychiatric participation. Until significant legislative reforms are enacted, most public mental hospitals will continue to operate under an enormous handicap, receiving many patients whose treatment has been unnecessarily delayed and whose illness has been aggravated by the process of seeking treatment. In the meantime, however, there is a great deal that the mental hospital can do—a great deal that may in fact help to bring about the needed action.

The mental hospital needs to develop a well-planned and vigorous public information and mutual assistance program with both professional and lay groups in the community. The hospital must aggressively seek the cooperation of screening and outpatient facilities in the community. One of the most effective ways of getting people to help you is to reach out and help them first. The mental hospital must take the initiative in making its services available to the various types of agencies which are apt to deal with emotionally disturbed people. An active public relations program can bring to the attention of social agencies, churches, the police, industrial management, and other "gatekeepers" of society the talents and abilities possessed by hospital staff. As those "gatekeepers" come to know the staff and to understand what they do, they will become willing to call upon the mental hospital for assistance, to consult with the staff on ways of handling mental health problems outside the hospital, and to try to develop more psychiatrically efficient patterns of referring patients to the hospital.

The hospital needs to make its existence known to the people of the community in which it is located. In most cases this is not done at the present time. Hospital staff sometimes seem to want to hide the fact that the hospital exists, and that they work there. It should come as no surprise, then, that large segments of the general public tend to view the mental hospital as a fact of life that should be "swept under the rug." In a number of places this situation is changing. Here again, the private mental hospital is showing us the way. The staffs of many of these institutions maintain close liaison with educational and medical institutions in the community.

The mental hospital needs to reach out in many different ways and to assume what should be its natural community role of psychiatric leadership. Various communities are beginning to conduct studies of the basic incidence and prevalence of mental illness in their respective areas. They are planning to gather data on the long-range use of psychiatric services to aid in intelligent planning for needed facilities and services. It would seem to me that the mental hospital has a great stake in the collection of this kind of information and in the implications of such data for developing future hospital

services. I would like to recommend that the mental hospital take active steps to cooperate in such studies where they are being carried out, or to initiate them if no other organization is ready to take the lead. I know full well that it will be said that the hospital does not have the staff time to do such studies. Nevertheless, it can at least serve as the catalyst in stimulating action by other community agencies and it can help provide direction and guidance. Personally, I think it can do more than that, if it has the will and the imagination.

A few communities have begun experiments for the treatment of acutely ill psychotic persons in their own homes, utilizing emergency psychiatric teams. Early experiences indicate that this technique is feasible and will substantially reduce the need for hospitalization of acutely ill persons. In those cases where the method has been tried, community agencies have become accustomed to call on the service for evaluation and treatment of their clients. The community has been made aware of the resources of the service by means of an educational and public information program aimed at both community agencies and the general public.

Much more of this type of activity needs to be carried on by the mental hospital in order to meet the needs of the mentally ill in the most efficient manner. The public mental hospital might also consider the advisability of adopting an "open staff" policy in order to provide continuity of treatment for the patient on his way into the hospital and to lay the groundwork for further continuity of treatment when he leaves. Many individuals who are in treatment with private psychiatrists cannot afford lengthy hospitalization in a private psychiatric hospital. Inpatient care in a public institution often results in a rude break in their treatment process, all too frequently with a period of regression. *What I am suggesting is the continued treatment of a patient by his private psychiatrist after admission to a public mental hospital.*

We need no less than a revolution in practice and attitudes, and the mental hospital must be in the vanguard of such change. It must lead and train. It can and must become one of the prime sources for psychiatric education of the general practitioner and of other appropriate professional groups. As it develops and exercises this type of leadership, it will be laying the groundwork for better treatment of the mentally ill in the community both prior to and following hospitalization, as well as for the establishment of a coordinated chain of mental health services in the total community. It will also be doing itself a great deal of good. One of the big problems in trying to recruit competent staff to work in public mental hospitals is the fact—and we might as well face it squarely—that in most instances the mental hospital does not appear to the young psychiatrist to be an attractive place. However, if the hospital develops new ties with the community and becomes the hub of new psychiatric programs, this situation is bound to change. With the inception of new activities, the hospital cannot fail to offer exciting and attractive potentialities for a young psychiatrist embarking on a professional career.

Just as the hospital needs to develop effective links with the community along the paths leading to the mental hospital, so it needs to develop and strengthen relationships of the patient with his family and the community while he is in the hospital. Unfortunately, it is still true in many cases that the mental hospital tends to be a total institution. Barriers to social intercourse with the outside, such as locked doors, walls, and geographical isolation, are built into the physical plant. The patient sleeps, plays, and works, all in the same place, with the same people, fitting into the single over-all goal of the institution. In other words, the life of the person in such a mental hospital is a group life, which is the antithesis to normal family living as we know it and cherish it in our culture.

As in most total institutions, the characteristics of the hospital tend, in and of themselves, to foster attitudes and behavior which further impede the progress of treatment. Patients begin to build a world around the granting or denial of minor privileges. Some patients adapt by manipulating the environment and finding a desirable refuge for themselves in the institution. They, in effect, "colonize" within the institution. Others tend to convert to the official attitude and to become "perfect patients." The more they succeed in this, the less likely are they to achieve optimal recovery and rehabilitation.

The hospital must provide the patient with an environment suited to his level of functioning in which he can establish good relations and, at the same time improve his ability to adapt to physical and social surroundings. One of the problems of the large public mental hospital is that there are insufficient opportunities for the patient to participate in small homogenous groups as well as in large heterogenous ones. Many hospitals are experimenting with small pavilions in which it is easier to develop a therapeutic milieu. Other hospitals are trying out new ways of orienting the patient so that he can become incorporated into the social system of the hospital, not as an anonymous patient but as an individual person whose goals are recovery and satisfactory social integration. This must be the objective even for those with the poorest prognosis, for if hospital workers entertain any other attitude, it will inevitably be communicated to the patient, who will think and behave according to this unspoken expectation.

It has become a truism that no matter what kind of therapeutic tools are used, patients get better when people work intensively with them, and get worse the more isolated they are from normal human contacts. However, since staff in most public mental hospitals is hopelessly overburdened, there is usually a regretful retreat to a fixed pattern of institutionalization. This is not entirely necessary even where it is impossible to secure additional staff. Much more can be done with visiting staff, with volunteer programs, and with the families of the patients.

Many hospitals are now experimenting with the use of student volunteers. At Harvard University, some five or six years ago, a group of students became interested in doing volunteer work at a mental hospital. As a result,

a well-developed volunteer program has been built up and the students themselves have requested formal instruction from the university's department of social studies. The volunteer program has resulted in a number of improvements at the hospital. In this particular case, interested students sparkplugged and helped develop the volunteer program. However, special situations can be created. Last summer, for example, the Western Interstate Commission for Higher Education sponsored volunteer programs in which 90 college juniors and seniors worked in mental hospitals in the states of Washington and Colorado. They were paid for their work, and received college credit. Here, as in the case of Harvard, new ties were built up between the hospital and the university. Mental hospitals need to take active steps in securing the necessary funds and sponsorship for such volunteer programs.

From a long-term point of view, the adult who has been a student volunteer understands the problems of the mental hospital and of the mentally ill. The benefits of this experience will go with him as he moves out into the community. He becomes an enlightened and potent advocate of better hospital conditions and facilities, he pleads for community mobilization for the development and exploitation of every effective force for pre- and post-hospital services. Thus develops the nucleus of the true therapeutic community.

I feel I would be remiss in my duties as President of the American Psychiatric Association if I did not call attention to the limitations on the therapeutic role of the mental hospital imposed by narrow professionalism and hierarchical stratifications in the social structure of the mental hospital.

A more democratic or egalitarian social structure between patients and staff, and a more communal exercise of roles by mental hospital staff tend to foster attitudes that emphasize the active rehabilitation of the patient. In hospitals which have experimented with manipulation of the environment for therapeutic purposes, the staff tends to operate as a treatment team, with the psychiatrist as the leader. There is also active communication between the hospital staff and patients' families. Both nurses and social workers visit the patients' homes and take an active role in involving relatives in the treatment process.

The whole new trend in social psychiatry is to work with the patient in the family setting and to stress cooperation with local health and medical resources. In those areas where general hospitals have fully developed psychiatric units, the psychiatrist spends part of his time in hospital service and part in extramural service including home visits. In some cases, the extramural service has become a small diagnostic unit attached to the hospital.

Family therapy has almost invariably proved beneficial wherever it has been tried. In some instances hospitals are using volunteers to help the social service staff work with patients' families, both before and after discharge. Work with families also helps to maintain the patients' ties with the outside world. Whatever is done in the hospital should, from the moment the patient enters, attempt to turn his attention firmly and positively back to the community. In other countries this has traditionally been the case. In Japan, for example, until recently, when a person was hospitalized for mental illness, members of his family would enter the hospital with him and would participate actively in the life of the hospital. At the present time, a special type of nursing aide is used as a constant companion to the mental patient and as a link with life outside the hospital.

It is as important for the staff as it is for the patients to maintain contact with the community, for staff will suffer from social deterioration just as much as patients if the hospital is isolated. In addition, without close contact with the community, staff cannot restore patients to health and are thwarted in their therapeutic efforts as well as in their personal relationships. One of the first things the mental hospital has to do is to become acquainted with its community. Here is a fertile field for a social psychiatrist on the staff of or associated with the mental hospital. The anthropologist can help the hospital to get to know the community thoroughly, and to find ways of establishing patients in congenial settings when they leave the hospital. Both the patient and the environment must be matched suitably if the patient is to make a successful transition back to the community. He needs to be prepared for his return through improved occupational therapy programs and training in job skills, both prior to and following discharge. He needs continued assistance in the form of social service counseling for himself and his family, half-way houses and sheltered workshops to help him through his convalescence, and better public information programs which will make the community more understanding about his illness and about the therapeutic advantages of making brief periodic visits back to the hospital when this is required.

Too often the mental hospital loses track of its patients once they are discharged. This is true even in the case of the so-called "extended home visit" systems. Some hospitals are beginning to take upon themselves the responsibility of seeing to it that their patients have the follow-up services they need. In Norway, for example, the mental hospital staff works outside the hospital and does its own follow-up work with discharged patients through outpatient clinics. The hospital social workers are active in ex-patient clubs and they carry on an active job placement program for their former patients.

We have heard much in recent years about the "open-door" policy—the policy of opening doors so that patients can move satisfactorily from the hospital into the world beyond. I do not believe the doors can stay open unless they become doors that open both ways, unless they are doors that let the community into the hospital as well as letting the patients go out into the community. For the open door to become effective, it must become a swinging door. A whole complex of paths and roads to and from the hospital must be constructed, and the hospital must assume a larger and more central role in the whole complex of facilities and measures which the community has to offer for the treatment of mental and emotional illness.

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Contents, February 1961

Presidential Address: *The Hospital and the Community* ..... *R. H. Felix, M.D.* 1
The Editor's Notebook ..... *Mathew Ross, M.D.* 9
Between the Lines 10
Keynote Address: *Needs of the Mentally Ill: Types of Effective Action Between the Community and its Hospital Facilities* ..... *Jack R. Ewalt, M.D.* 12
Faculty of 12th Mental Hospital Institute 15
Preface: The Provision of Appropriate Treatment: *Hospital and Community Collaboration* ..... *Dana L. Farnsworth, M.D.* 17
Discussion Areas—*Treatment:*
- Controlling Bodies 21
- Professional Bodies 23
- Community Service Bodies 28
- The Scientific Community 29
- The Patient-Community 31
- The Patient's Social Community 33
- The General Public 35

Preface: The Provision of Appropriate Aftercare: *Hospital and Community Collaboration* ..... *M. B. Stokes, M.B.* 36
Discussion Areas—*Aftercare:*
- Controlling Bodies 39
- Professional Bodies 40
- Community Service Bodies 43
- The Scientific Community 44
- The Patient-Community 45
- The Patient's Social Community 46
- The General Public 48

Summary: *Support for Treatment and Aftercare Programs Depends Upon Positive Hospital Leadership* ..... *Jack R. Ewalt, M.D.* 49
Psychiatric-Legislative Panel 52
Simultaneous Sessions:
- Organization for Research: The Experience of the 16 Southern States 54
- Films as Effective Teaching Tools 55
- Distribution of Financial Responsibility 58
- Nursing Programs in the Open Hospital 60
- Management of Family Tensions 61
- Financing Administrative Research 63
- Problems of the Community in Initiating and Sponsoring Psychiatric Programs 65
- Community Administrative Training Program 66
- Evaluation of Private Psychiatric Hospitals in Community Service 68

Have You Heard? 72
Have You Read? 72
News & Notes:
- Quarterly Calendar 74
- News Stories 74
- People & Places 75

Roster of Delegates 78

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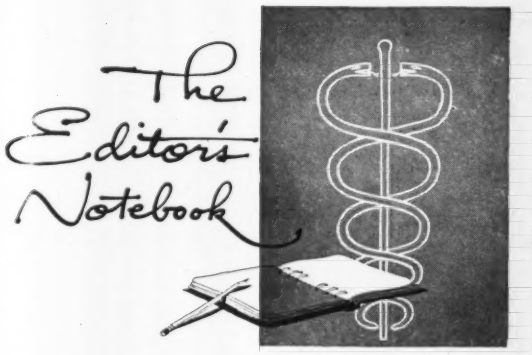


PSYCHIATRY IS CHANGING, not only through choice, but also through social pressures. The nature of the change was dramatically and comprehensively detailed in the discussions at the 12th Mental Hospital Institute.

Today we prepare to march forward from our enforced encampment on the isolated grounds of state hospitals into the urban and suburban communities which impinge upon the hospitals both literally and symbolically. Acting upon our profession are a number of social forces, which not only provide stimulus toward new development, but also offer new resources for the battle against mental illness. The Program Committee, as a means of conveniently discussing some of the major forces at work, identified seven very broad groups for consideration.

Our rapidly developing philosophy calls for total treatment of all, rather than for intensive treatment for some and custodialism for the rest. It is commonly acknowledged that psychiatry cannot accomplish this objective unaided; even the concept that the "team" consists of the psychiatrist, the psychologist, the nurse, and the social worker is giving way to the realization that we must also include the skills and talents of ministers, teachers, lawyers, businessmen, public health nurses, and perhaps of members of yet-to-be-born new professions. Along with this change in philosophy comes a great wave of optimism about the possibility of making more useful citizens of our chronic patients, either within the hospital or beyond it in a protected setting suitable to their residual assets.

The discussants at the Institute were sharply aware of the dangers inherent in this phase of rapid change and development. Perhaps the most threatening is the development of intraprofessional schisms, based on artificially contrived disagreements about the role of the mental hospital. One school of thought anticipates the demise of the large mental hospital as soon as other facilities can be devised to take its place. Another believes that the public mental hospital is and will remain the most suitable facility for the treatment of the severely mentally ill, provided that sufficient community supports can be devised to give it the help it needs to do the job.

Note that both schools of thought believe in the need for community supports. It hardly seems to matter whether these supports are conceived by some as leading ultimately to the demise of the mental hospital, and by others as a reinforcement for it. History alone will prove who is right. But both agree upon the kind of supports needed.

A second danger lies in the possibility that our enthusiasm for community psychiatry may lead to deterioration of the mental hospitals. There is real need to be careful that their needs do not get overlooked in the stampede for community services. We must give direction to a further elaboration of community psychiatry to the end that we will achieve a proper integration between hospital and community, to enable the hospital to develop as a major component—indeed, as the driving center of the total treatment program.

It is obvious, then, that the hospital psychiatrist, as well as his colleagues in psychiatric clinics, in general hospital units, and in private practice will have to assume a new role in the years to come, if our new philosophy is to develop properly. The American Psychiatric Association is planning to hold a conference on the graduate training of physicians (residents) to achieve competence as general psychiatrists, and to prepare for careers in clinical work, research, teaching, and public service. Special emphasis will be placed on assessing the relative adequacy with which present-day training is preparing the psychiatrist to meet changing medical, social, and public needs, and what modifications suggest themselves to meet these needs more effectively. Such discussions will obviously make repeated reference to the material produced by this 12th Mental Hospital Institute, which points up some of the changes in the current practice of psychiatry both inside and outside the hospitals. This conference will doubtless spark efforts on the part of allied professions to develop curricula and training programs for themselves, which will dovetail with the changing practices of psychiatry.

Much of the challenge of the decade to come is implicit within these Proceedings. The future is clear only in that we know the way ahead is long and arduous. As Bunyan said: "It happens to us, as it happeneth to wayfaring men: sometimes our way is clean, sometimes foul; sometimes uphill, sometimes downhill; we are seldom at a certainty; the wind is not always at our backs, nor is everyone a friend that we meet in the way."

Matthew Ross, M.D.

For further delineation of the opportunities and threats of community psychiatry see Ross, Mathew: Editor's Notebook, Ment. Hosp. 10:4:12, April 1959. Ibid 11:5:15, May, 1960. Ibid 11:8:13, October 1960. Community Psychiatry as an Opportunity for Medical Leadership, Arch. Gen. Psych. 3:11:478-89, November 1960.

Between the Lines

THE EDITORIAL STAFF

THIS ISSUE OF MENTAL HOSPITALS, the largest ever published, contains the Proceedings of the 12th Mental Hospital Institute, the largest ever held. The final count showed a total attendance of 501 people, including 11 A.P.A. staff members. The Institute was held from October 17 through 20 at the Hotel Utah, Salt Lake City.

The Program Committee, under the chairmanship of William S. Hall, M.D., South Carolina, held four planning meetings to formulate the discussion outlines and format for the Institute. Evidently their plans met with approval. A questionnaire sent out by the committee two weeks after the end of the Institute received 220 replies, most of which indicated satisfaction both with program content and with the small discussion-group plan. On the committee with Dr. Hall were Alfred H. Stanton, M. D., Mass. (Chairman of the Program Committee for the 1961 Institute); James E. Gilbert, M.D., South Dakota; John P. Lambert, M.D., New York; and Mr. James C. Hodges, Michigan.

The Mental Hospital Services and the participants at the 12th Mental Hospital Institute owe a sincere debt of thanks to William S. Hall, M.D. (left) for his inspired chairmanship of the Program Committee and his unfailing support during the entire meeting.

Of those attending, 253 were physicians; 96, business administrators; 41, nurses; and 26, social workers. The remaining 74 included trustees, legislators, volunteer coordinators, psychiatric aides, psychologists, mental health association executives, clergymen, sociologists, and others from mental hospitals, public and private, or working on the state or provincial level.

Forty-seven states were represented, as well as the District of Columbia and Canada. New York State, with 37 people, had the largest representation, followed by California with 30. The home state of Utah came third on the list with 29 representatives. Canada sent 14 people.

Preparing an edited version of the millions of words produced by five hundred enthusiastic discussants over a three-day period presented some problems. Much credit is due to the recorders and discussion leaders, who worked hard and long to formulate some definitive conclusions from their groups' discussions. Since space limitations in the discussion reports make it difficult to include the names of the recorders, they are listed here in alphabetical order: M. M. Bateman, M.D., W. Va.; C. L. Bennett, M.D., N. J.; Mr. T. A. Bravos, Calif.; C. H. Cahn, M.D., Canada; Miss Margaret Cavey, Va.; Preston E. Harrison, M.D., Texas; Mrs. Miriam Karlins, Minn.; George D. Katz, M.D., Utah; Morgan Martin, M.D., Canada; Aaron S. Mason, M.D., Mass.; Mr. Delbert Mesner, Neb.; Mrs. Frances T. Roberts, Conn.; W. A. Sikes, M.D., N. C.; Mr. Nathan Sloate, Calif.; J. W. Southworth, M.D., Ind.; F. G. Tucker, M.D., Canada; Mr. Calvin Wilcox, Del. The sincere thanks of all participants and of the editorial staff of the magazine are hereby tendered.

ANONYMOUS QUOTATIONS

The main editorial problem was to eliminate repetitious material, since inevitably several discussion groups concentrated upon similar areas, and their reports bore great resemblance to one another. A real difficulty was the fact that, while many direct quotations appeared, most had not been attributed to their authors. In the interests of fairness and consistency, therefore, few names have been mentioned in the accounts of the group discussions, even though many will recognize, we feel sure, their own specific contributions.

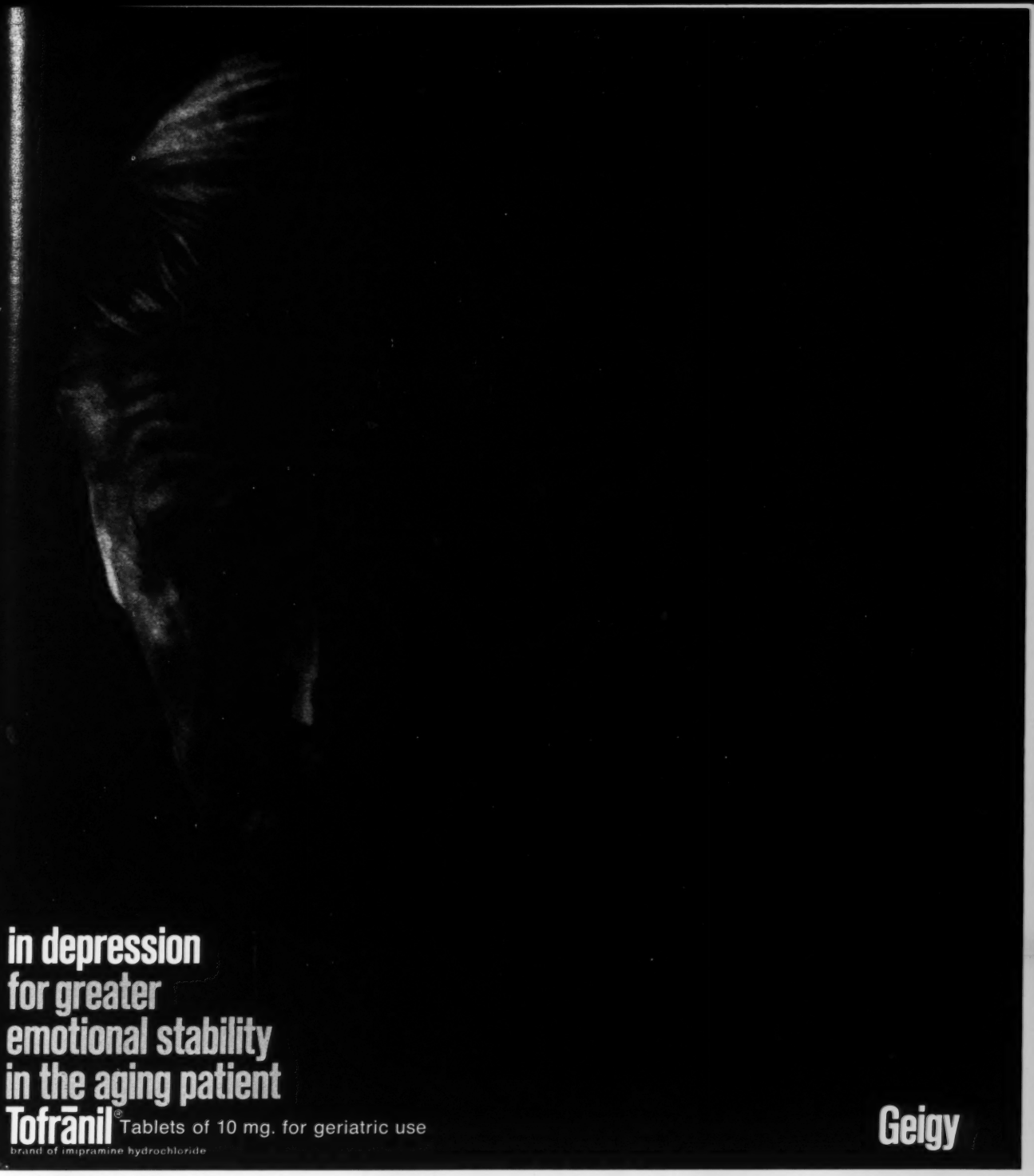
The Academic Lecture, "The Demographic Variable," was an examination of the impending population explosion. It was delivered by Charles Westoff, Ph.D., of New York University, and the Office of Population Research, Princeton, N. J., and was published last October in monograph form. A very few copies are still available from the Mental Hospital Services on request.

The Local Arrangements Committee was under the chairmanship of A. H. Fechner, M.D., with O. P. Heninger, M.D., A. C. Thurman, M.D., and E. L. Wiemers, M.D. Mrs. Fechner headed the Ladies' Committee, assisted by Mrs. Heninger and Mrs. Thurman. In addition to the tours and entertainments her group organized for fifty wives of institute participants, Mrs. Fechner found time to give much voluntary assistance to M.H.I. staff members.

The film program this year was organized and operated by the Mental Health Film Board. Present for this purpose from the M.H.F.B. were Irving Jacoby, Producer, Alberta Jacoby, Executive Director, and Irene Malamud, Educational Consultant.

Hospital tours, arranged for Monday, October 16, before the plenary sessions started, included visits to the Utah State Hospital at Provo, and the Veterans Administration Hospital, the University Hospital, and the Latter-Day Saints' Hospital in Salt Lake City.

The Institute closed on an unusual note—a barbecue party in the mountains about 30 miles from the city, in the early evening of October 20.



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KEYNOTE ADDRESS

By JACK R. EWALT, M.D.
Professor of Psychiatry, Harvard Medical School
Superintendent, Massachusetts Mental Health Center
Director, Joint Commission on Mental Illness and Health

Needs of the Mentally Ill:

Types of Effective Action Between the Community and its Hospital Facilities

MY FUNCTION is to outline the goals of the Institute discussions and hopefully to inspire you to bring to bear on the subject the large experience and wisdom you possess as a group. For this purpose we are a community bent upon pooling our knowledge, energy, and good will to bettering the lot of the mentally ill person.

Here we do not concern ourselves with the promotion of man's well-being or the building of resilient spirit and character, but rather we follow the admonition of Gelal Ed Din Mohammed Asaad (8), a Persian mystic, who in the 15th Century emphasized that mental health was a different consideration than mental illness and needed other approaches. Here we concern ourselves with the mentally ill, with those particular mentally ill who, by social processes imperfectly understood, are selected by the community or by self for medical attention or some type of official intervention.

Because no two hospitals represented here are identical, and because the communities in which they are located also differ, we will not discuss their comparative merits and deficiencies. Perhaps we can dispose of this aspect of our deliberations by agreeing that an inventory should be made of the hospital and the community in which it lives, an inventory of incompletely used resources and of unmet needs, before changes in patient care are instituted. Our projected study will include the important cultural aspects of the community, not the least of which is the concept of appropriate things to do with and for people who are disturbing or upsetting some segment of society. Lambo (6) out of his experience in Nigeria, has stated that, no matter how we plan, nonmedical aspects of the community will influence and modify the effect of our programs. He is specifically referring to superstitions, and the activity of native healers —witch doctors. Our own society, too, has superstitions and witch doctors, but just because they are part of our culture and our concept of what is proper, it often takes an outsider to identify our witch doctors and to detect our superstitions as clearly as we can see them in African culture. But also, as in Africa, once identified they should be further examined by the insiders and outsiders in collaboration to determine how one may fully exploit the useful features of a superstition and "fixed opinion," and eliminate those impeding the proper care of patients.

Now we turn to consideration of the needs of the mentally ill in a more detailed way, needs that vary within an individual patient at different times in his illness, and needs that vary between patients.

Some patients on becoming ill recognize their condition. The hospital should have clinic facilities to which these patients may come informally and without waiting. Some type of emergency service at or away from the hospital may serve this purpose. To be most effective the laws, regulations, and practices of the hospital must be structured so that they facilitate rather than obstruct prompt attention to people who think they need it. To fill this need for early diagnosis and treatment there are only 1,234 psychiatric clinics in the United States. At least only that many were reported and countable in 1958 (11). This number includes Veterans Administration and child psychiatry clinics. About 10,000 professional persons serve these clinics and over half of these are social workers and psychologists. Only 30 per cent of the man-hours available in the clinics are psychiatric time. Approximately 400,000 persons are seen in these clinics each year.

In those forms of mental illness which patients

deny, other people—the family, the family physician, friends, or employers—must identify the problem and take measures to provide the necessary treatment. Advice of trusted loved ones will cause some patients to seek consultation and treatment. For others, more aggressive intervention is required.

Not simple is the problem of how one obtains a medical certificate when the patient is disturbed and stubborn in his refusal of help. Home visits must be made, often under very adverse conditions. We cannot expect cooperation from physicians, hospitals, or clinics in making such visits, unless they can be protected to some extent against damage suits by paranoid persons. Legal hazards of this type can be greatly reduced by education of the courts and of practicing attorneys. Demonstrations at the mental hospital, using as illustrative cases patients who have been properly handled as well as those who were the victims of uncoordinated services, will help the legal profession to understand that a mentally ill person has a right to proper treatment, in addition to those civil rights which the law is dedicated to protecting.

The education of the community so that patients of all types may benefit from the resources available is the responsibility of the mental hospital. This responsibility must be willingly assumed and effectively discharged if the hospital is to retain its proper role as the community center for mental health activities.

We must work even more at public education, mindful that current techniques seem to be only moderately effective. Some studies suggest that public education by mass media can make people aware of a topic, but will not give them depth of understanding unless they studied science in high school or college (9, 15). This is a trend also shown in a study of the Joint Commission on Mental Illness and Health (5) in which education level and age were most highly correlated with interpretation of symptoms of ill health as having possible psychologic origins. Some suggestions as to better ways of communicating information to the public come from Nunnally and Bobren (10): "Relatively high anxiety messages depressed public interest. Among those messages with anxiety, the use of either an impersonal approach, or the giving of a solution raised the public interest, and the use of both an impersonal approach and the giving of a solution created more public interest." The best survey of the topic is in a series by Brim (1).

At times persons first show unacceptable behavior in public and the police intervene because of the accompanying social disturbance. To be helpful the police must have some guidance in detection of the elements in disturbances that suggest psychotic illness as a probable cause. They must be instructed as to effective methods of intervention and they must have a place to take the person for a professional opinion as to his probable mental state. To discharge its role in this area, the hospital should devise ways of instructing the police in management of disturbed persons, and provide consultation on a 24-hour basis so that persons apprehended may be appropriately managed.

Manifestations of mental illness may initially come in the work situation. Foremen, union stewards, industrial physicians and nurses, and people in higher echelons of management need instruction in detection of situations among personnel that produce emotional stress and may lead to illness. Further, they need instruction in the behavior changes suggestive of incipient mental disorder. May I admonish that such symptoms and signs (2, 3, 7, 14) be those detectable in the work situation and in routine health examinations. To advise adoption of techniques requiring hours of time, such as psychological tests, or a series of psychiatric interviews, is unrealistic and cannot be implemented even in the unlikely event the suggestion would be adopted.

Another major point for interception of incipient mental illness is the family or child-care agency. Many persons with beginning mental decompensation so behave that the family situation becomes noticeably disturbed. Aid sought by family members or offered by the agency should include an estimate of the mental health status of the total family membership, as individuals and as members of the group. The hospital should have an effective liaison with the family agencies, offering psychiatric consultation as needed, and clinics or institutional care for those clients too ill for management by the agency staff. In many areas the hospital social service department and the local health or welfare department will find it necessary to improvise the equivalent of a well-organized family service agency. In 1957 there were 284 qualified family service centers in the continental United States (11). In addition, 1,157 of the 3,103 counties had neither public nor private child-welfare agencies. Nonetheless, some local groups will be under some pressure grappling with family problems, and the greater the degree of improvisation the more psychiatric consultation will be required.

The person with illness manifested by antisocial behavior often comes to the court. His appearance may be at his own request to inquire into the propriety of a commitment to a mental hospital, or he may be a defendant in a major or minor complaint filed on behalf of the people by a public prosecutor—usually called a district attorney. In either instance the judge may have reason to inquire into his mental state. Such consultation should be available to the court from a clinic established to serve the court and its clients. If no such consultation clinic exists, legislation may be required to establish one, or to enable the court to refer the defendant to the mental hospital for the necessary examination.

Persons committed to prison may become mentally ill while rendering the law its required penance. Others may have carried in to prison early and undetected psychoses. Another, and larger group, suffer from neurotic or sociopathic disorders whose principal manifestations are the behavior that invited the incarceration. Some members from all these groups are amenable to therapy, appropriate to each patient. Such therapy will be given only if the hospital or some community agency supplies it. Hospitals have a legitimate self-interest in such services in the correctional institutions; if the services are lacking, some judge, thinking ahead of the physicians, will

commit offenders to the hospital for the treatment he believes is available. Patients placed in therapy in the correctional institution will in many instances require and want a continuation of treatment when on parole, and sometimes after discharge from parole.

The medical manpower for the services patients need during onset of illness and treatment at the community level will not be found entirely within the staff of the mental hospital. Some system must be organized to use the local psychiatrists and the other physicians in the community. The system will vary with the number, skill, and interest of the local medical associations. Few will volunteer to help, but proper proselyting may recruit a number of able and willing workers. Someone must initiate these activities. Why not the hospital staff? Some of these services may be ably supplied by other public or private agencies already at work in the area. In this fortunate event, the hospital will need to elicit their cooperation in extension of services to psychiatric patients, and then to arrange with the detection sources to use the services offered by existing agencies. And, importantly, the hospital and its staff must be ready to offer inpatient care, and consultation on an emergency basis. In most communities the hospital must assume an additional responsibility if it is to make the best use of the area medical manpower. This responsibility is to initiate refresher courses so that general physicians and specialists may learn anew psychiatric skills previously used to varying degrees in their day-to-day work.

Service in clinics and in general hospital units, geographically separated from the mother hospital, will aid in providing better service to the patient so ill that institutional care is necessary. The staffing of such units will no doubt require further cooperation from the medical community. Authorization to pay costs of patient care in services separate from the mother hospital, geographically or administratively or both, may require action of trustees or legislature or some groups responsible to the public for the operation of the public hospital. Steps to insure the education of these groups and to gain their cooperative action will also fall to the hospital staff and to such other community helpers they may mobilize.

Many of you and your colleagues in the community have already made major advances in this area. Sixty-two of the 85 Blue Cross plans in the United States offer 21 or more days of care per benefit period (1960) (12). Further, the number of general hospitals accepting mental patients was 789 in 1958 and undoubtedly more accept them today. General hospitals admitted 257,300 mental patients in 1958, a rate per 100,000 population higher than the admission rate to the public mental hospitals (13).

The mental hospital proper, with its substantial number of patients and staff, must be served even as it serves these other units. Without a vigorous first-class patient-care program in the central institution, community services may not long survive or even start. The confidence of the supporting and the patient communities will be won by a record of effective treatment and rehabilitation of sick people, and not by trick slogans or widely publicized "new ways" that exist only on paper. Such confidence in the ability of the base hospital to effectively plan and execute a treatment program is a necessary ingredient for a community to authorize, support, and use new services adapted to care of patients in peripheral units nearer their homes.

Perhaps this recommendation for strengthening of the home base is unnecessary. The state hospital has been investigated, inspected, reorganized, converted, divided, dispersed, and even abolished, in fact or in theory, by countless imaginative persons motivated by a variety of urges. The state hospital survives, however, and is an amazingly tough and resilient social institution. The state hospital stays with us because it serves a useful purpose and no one has yet devised a replacement that will serve the same purpose as well with our current resources in men and money. The state hospital is the center of our helping agencies for the mentally ill. It is the only one of the social institutions mentioned that is indispensable. The acute treatment center, the emergency service, and the experimental hospital may all be eliminated and the community can still function. Abolition of the state hospital would result in chaos in a short period. The new and more prestigious hospitals and clinics would have no place to send their failures. Such failures, some disturbed but many just stubbornly ill, would soon fill the beds of these new facilities, leaving no room to receive the incoming cases.

This restating of the obvious does not mean that the status quo is desirable. The use of the large hospitals as a base for extending the services mentioned into the community is the next step, a step already taken in some instances. The superintendent and key community leaders need to review the use of their present manpower. Perhaps the psychiatrists could be better employed in the community extensions, in the clinics, and in general hospital units. Perhaps some of the continued treatment wards can be managed by rehabilitation teams or group-work teams, with medical care limited to general supervision of the health and the medications of the patients. Mind you, I am not advocating this particular way as the salvation of the state hospital, but I am urging experimentation with new techniques for handling the masses you have inherited from past years of accumulation. The techniques for care of the chronically ill need review and research. It is possible that chronic cases of all types may in time be yours to plan for and to treat. We have no reason to believe that chronic patients will disappear in spite of present and expected new treatment techniques in all fields of medicine.

Rehabilitation of patients recovering completely or in part has been extensively described in other conferences and in research reports (4). Here we will say that the hospital must establish contact with the rehabilitation agencies in the community. Most states have rehabilitation services with workers dispersed through the state. In some instances the hospital and these agencies have established working relations to their mutual benefit. The hospital offers consultation services and training courses for the rehabilitation workers as they seek to improve

their understanding of the special problems of working with the mentally ill. The agency functions as an aid in placing many patients and former patients in suitable employment. Prejudice against employment of former patients can give way to preference in some jobs. A personnel director for a large Massachusetts company said the use of hospital patients placed by the rehabilitation workers made it possible for him to seek help in case employment problems arose. He had a ready-made consultation and referral source in case of trouble, whereas he had no comparable record for employees off the street, and no ready place to turn to for consultation and help if problems arose.

In our deliberations, the patients' needs must be the focus, and the central theme that of interaction between the mental hospital and those communities which can provide services for different patients at different times in their illness. If suitable services are to be offered with our present and projected manpower and financial resources, the total potential of the community must be totally utilized in an integrated program. New services are to be created only when existing ones cannot fill a needed function. And my main theory is that some community agency must assume the responsibility of coordinating all available services into a functional whole, irrespective of the sponsorship of the individual agencies. It is my belief that the state hospital can and should serve this basic, central, coordinating function. •

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PREFACE

By DANA L. FARNSWORTH, M.D.
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The Provision of Appropriate Treatment: Hospital and Community Collaboration

The provision of appropriate treatment means the hospital's role in everything of an appropriate therapeutic nature that occurs between the time the patient or his family become aware of illness and the time of entry into the hospital, or recovery, including the period of hospitalization.

WHILE PREPARING FOR THIS INSTITUTE I had occasion to talk about the topic of our deliberations with a group of community leaders, among whom were some physicians. I asked them if they would be willing to express some of the sentiments and criticisms they had heard or had themselves experienced concerning relations of persons in the community with staff members of mental hospitals. They were only too ready to do so. Assurances were given that their identity would not be revealed and that they need not feel the necessity of proving their statements. I was probing for the nature and extent of their feelings rather than for purely objective data concerning the hospitals.

The consensus of these feelings was about as follows: "Few of the personnel in mental hospitals seem to feel that parents or other relatives matter. Others who are not relatives but who have a legitimate concern for the patients' welfare are also passed around from person to person. Cleanliness is of little moment, even in situations in which patients are not involved. Some doctors are so preoccupied with the dynamics of the patients' illnesses that they have little time for the small amenities and common courtesies that mean so much to patients and relatives. Patients are tossed back and forth between therapists and administrators. There is little evidence of humanity, love, or personal concern for patients. Patients are not aware of what they may reasonably expect in hospitals. Conditions in admitting rooms are depressing. Referring physicians are seldom given reports of their patients' progress. Patients are shorn of their personal dignity as well as most of their possessions when admitted to a mental hospital. Most doctors are courteous but other staff members often give one quite a hard time."

My first reaction was that these criticisms were very unfair. I know that the administrators and psychiatrists who run the hospitals under criticism are doing the best they can under the circumstances. All of them deplore impersonal attitudes toward patients as much as we do. But the stubborn fact remains that many persons believe these and even worse things about mental hospitals. What is even more embarrassing is that in many hospitals even worse conditions exist, and in the best hospitals some of these conditions exist at least part of the time. Our problem has two main facets—removing the causes for such criticisms on the one hand, and correcting the misconceptions and misinterpretations that persist long after the deplorable conditions have been corrected. This means long and careful work with all persons connected with hospitals—guards, telephone operators, attendants, nurses, and physicians—literally everyone.

How can we keep public knowledge and opinion abreast of the progress we are making in the care and treatment of emotionally disturbed persons? At best, there will always be a time lag in the community's awareness of such progress. On the other hand, once we have gained a community's confidence, its members may be inclined to believe only the best of what they hear. The time lag in information works both ways.

For one thing, we need a vast program of public education regarding the nature of emotional disturbances and the needs of those people who are severely handicapped by emotional conflicts. What this public education should consist of and who should promote it are subjects of immense complexity. Emotions become very strong when these questions are raised for discussion since so many people have firmly fixed notions as to what the answers should be. Furthermore, these notions may be highly contradictory.

A recent article in a national magazine, based on the

report of the National Assembly on Mental Health Education held at Cornell University in September, 1958, seems to decry any kind of mental health education and implies that helping those who are mentally ill is the only thing that offers any real hope of progress. As a reflection of what went on at this conference, the article, in my opinion, was grossly distorted. A major problem that confronts any practitioner of preventive medicine is that whenever he prevents any illness or tragedy he destroys the evidence that anything has been accomplished!

I firmly believe that both the treatment of mental illness and the promotion of mental health are necessary in any well-conceived community program designed to reduce crippling emotional conflict. To throw up our hands and stop promoting mental health programs because we cannot define mental health or can portray results only inexactly is to show both lack of common sense and lack of courage. Improving mental health in a community resembles, in some ways, the efforts of parents to improve family life. There may be few quantitative guideposts, but good and bad practices are obvious. Whether we think promoting mental health is feasible is of small moment—we can all unite on attempting to *prevent mental illness* and let the semantics go.

A part of the difficulty we face in developing sympathetic and understanding attitudes toward emotional distress on the part of community leaders stems from prevailing concepts of mental disease expressed by physicians who are not psychiatrists. The idea that all illness in which the human being is attacked by something from the outside, a bacterium, a virus, a traumatic object, or from the inside by a new growth or a degenerative process, is accepted far too literally. We often hear the statement, "Mental illness is just like any other illness," as if it were as clean-cut in its origins and manifestations as a bout of Asian influenza. The more we can get across to our lay citizens the idea that mental illness is usually the result of long-continued, adverse emotional conditions, the faster will be our progress. Organic conditions, inherited traits, and biochemical abnormalities are all important, of course, but undue reliance on these explanations tends to reduce the feeling of responsibility assumed by community leaders and professional people. Emphasis on social and cultural factors as precursors of mental disease heightens a sense of responsibility, but may also arouse many strong resistances. Some of our colleagues even see something vaguely subversive in such an approach. Unfortunately those who regard human behavior solely from the social and cultural point of view are as liable to distortions as are those whose approach is purely physiological.

One simple way of getting helpful ideas across to the general public is to point out the basic sources of conflict, unhappiness, and inefficiency. These include isolation or feelings of isolation, rejection by persons one wishes to love, and prejudice and its effects, particularly unfair discrimination. Children who have inadequate or inappropriate examples set by their parents are particularly vulnerable to emotional stresses. If the behavior of parents or other influential adults in children's lives is so inconsistent that children are unable to predict when their own behavior will be appropriate, potential trouble is brewing. Children are remarkable imitators; unfortunately, they are not selective as to what they imitate.

Persons who experience these interferences and deprivations—and everyone does—make allowances for them. But when any one person sustains too many impediments to successful adaptation to his circumstances, his capacity to make appropriate allowances decreases or disappears. This illustrates an important point, i.e., that we who are trying to promote mental health and prevent mental illness are not suggesting that we can eliminate all conflict, anxiety, fear, or other temporarily unpleasant emotions. Indeed, even if we could do so, it would not be desirable. But we are trying to help people learn to deal with the usual hazards of living without paralysis of will, violent resentment, or crippling anxiety and, as a result, with increased maturity.

If one or any combination of these inhibiting factors affect a person over a long period of time, a variety of results may ensue. Whether a given individual will in fact develop evidences of emotional decompensation depends in large part on his own vulnerability, a propensity which in itself may serve as a subject for public education. Those who suffer may do so in a variety of ways, ranging all the way from simple unhappiness or discontent to a full-blown psychosis. Some may become inefficient in whatever they attempt to do, or protect themselves by apathy or alienation. Some will become anxious, suffer from physical symptoms, or develop neurotic defense mechanisms. Others will "act out" their feelings at the expense of society. A variety of escape devices will be adopted by a considerable number—overwork, improper use of alcohol and drugs, wanderlust, or excessive sleeping. A few may find an outlet in membership in one or more "hate groups."

But we are herewith primarily concerned with those persons who have been exposed to adverse conditions so long and with such intensity that they have lost a part of their ability to assess reality correctly. Most urgently, we wish to get across to the general public that mental illness does not strike people arbitrarily and without reason. In so doing, we do not wish to frighten them unduly or to give an oversimplified version of how emotional stress brings about illness. All too often the talks given by psychiatrists from mental hospitals contain so much description of dramatic psychopathology that the connection between this and the more mundane factors which it brought about is lost. Many people, who are unaccustomed to hearing of symptoms and behavior commonplace in a mental hospital, use the same defense mechanisms as they do when listening to civil defense programs designed to get us all to construct bomb shelters. "It won't happen to me." Still others may be sufficiently sophisticated to look upon such talks as too elementary, and complain because they are not told what they can do to help prevent mental illness. Obviously no speaker can please everyone, but great care is essential in estimating characteristics of the audience.

We have gradually evolved from our experience up

to now a series of principles regarding treatment of the mentally ill with which most of us are in agreement. They include:

1. The importance of respect for patients as persons.
2. Self-esteem and personal dignity of patients should be respected and cultivated.
3. Hospitalization should be looked upon as temporary. If a patient can be helped he will soon return to the community. If he cannot be, a home suitable for one with his capacities and difficulties should be found.
4. Hospital life should encourage independence, not induce helpless dependency.
5. Small hospitals and treatment units are more conducive to carrying on such personal programs than are large impersonal institutions.
6. Good hospital programs are based on a high degree of community understanding, toleration, and support, particularly from the local opinion-makers.
7. The more conditions in hospitals approximate optimum conditions of family and community living, the more effective treatment is likely to be.

These principles should be repeated over and over to influential persons in the communities supporting mental hospitals.

Perhaps a look at some of the obstacles militating against full understanding of the mental hospital's function may aid in the removal of some. I do not suggest that every member of a community should know all that goes on in mental hospitals—this is utterly impractical. But, I do think it is as necessary for the community leaders and other molders of opinion to be aware of what goes on and why, as it is for them to know and have confidence in the bankers, insurance officials, business men, and other professional people and organizations in the community.

Isolation of the public mental hospital from the general community has always been and continues to be a major obstacle. In recent years, this fact has become so obvious that most new institutions are built near centers of population and medical training centers. But the correction of geographical isolation does not always solve the problem. Recently I was talking with a mental hospital staff member in a psychiatrically remote area about the main problems he faces in his institution with its 2,500 patients. For the most part the physical facilities are quite adequate. Much attention had been paid to providing treatment for the obvious physical ailments of the patients. But I was disturbed to hear that the superintendent does not want more professional help (he has four physicians on his staff); he feels that the ideas they bring with them always cause more trouble than they are worth. My informant said, "A lot of the superintendents feel that way." I wondered first, "Is my informant correct in his portrayal of his chief's attitude, and if so, is this attitude prevalent in the country?" I am sure it is not the prevailing point of view among superintendents of good hospitals, but I am aware that there are sections of the country where the mentally ill get more consideration than they do in other regions.

Another obstacle to effective community understanding is the relative infrequency of contacts between staff members and other community leaders. It is not enough for the chief administrator to participate in community affairs. Unfortunately, the combination of pressure of work, relatively low salaries, and restrictive attitudes make such community participation difficult for the average hospital psychiatrist. The more he confines himself to caring for his patients, the more ingrown he becomes, tending more and more to interpret behavior in terms of the presence or absence of severe mental illness *in persons who are not patients.* Psychiatrists who work in mental hospitals, perhaps more than any other professionals, need the antidote of participation in a variety of activities in which mental illness is not in the foreground of consideration. All of us, no matter what our business or profession, tend to become prisoners of our own experiences, but some freedom and independence of thinking can always be retained if we become aware of chauvinistic tendencies within ourselves and take appropriate measures to combat them.

The ataractic drugs despite their undeniable benefits have created many new problems. That many chronically ill patients have improved under their influence is increasingly apparent and enormously encouraging. Others have not been appreciably helped. A recent "successful" case in which a professor's symptoms of depression were effectively held in check by a tranquilizer illustrates my point. The physician who prescribed the drug did not "believe" in psychiatry and warned his patient against becoming involved with psychiatrists who would stir up his personal troubles and make him worse by talking about them. The only disadvantage of the "successful" treatment in this instance was that, although the professor was not depressed, he was apathetic and unable to do the active intellectual work that was necessary to carry out his teaching.

I am reluctantly forced to the conclusion, based on a great deal of experience with all the professions whose function it is to help people who are at odds with themselves or others, that the resistance of the medical profession generally to the ideas that are essential in developing community programs for mental health and treating emotional illness is very discouraging. I do not mean by this that outstanding leaders in the medical profession are opposed to our programs. I am referring to individual physicians whose experience with psychiatry when in medical school and since they graduated has left them with incorrect and distorted ideas of what mental illness is and what resources are available to combat it. One of my colleagues who directs a community mental health clinic, and is doing it well, has found that his chief opponent is a very successful and most respected physician who looks upon talking with patients as an utter waste of time. As a board member of the clinic, he repeatedly says, "When are you fellows going to learn to work?" Then he relates how he sees 70 to 80 patients daily and "these people in the clinic take an hour to see one patient." It is easy to see why my friend covets more understanding of his clinic's function. It may be too that the members of the legal profession are as resistant as our colleagues; that is certainly debatable.

Many of the medical columnists who so impress edi-

tors, and apparently many readers, also display gross lack of awareness of the complexity and subtlety of mental illness and health. There isn't much we can do about this until or unless we develop some good writers and interpreters who do know how to get sound ideas across to the public.

The "either/or" attitude toward etiology displayed by all too many of our own colleagues in psychiatry continues to be regrettable, and is a source of much ammunition for those who resist optimum care of the mentally ill and mental health promotion alike. No one point of view about the management of mental and emotional illness is so predominant that it precludes all other approaches. Progress in the pharmacology of disease can and should go hand in hand with advancement in the understanding of unconscious processes, the range of dynamic psychiatry, and application of findings derived from sociology, anthropology, and clinical psychology. Unfortunately, we persist in a kind of competition and disparagement of one another's activities that uncomfortably resembles that between different religious sects. Our lack of appreciation and tolerance of each others' efforts gets in the way of effective educational programs for the community.

Still another important obstacle is the idea on the part of legislators and taxpayers that everything necessary has been done when fine buildings have been erected, and it can be plainly seen that the mentally ill have better housing than they ever had before entering the hospital. The whole concept of psychotherapy and environmental pressures toward recovery is much more difficult for the average uninformed person to grasp, than is the simpler but traditional treatment by medication. The recent trend toward improving the quality and the number of staff appointments and emphasizing early and intensive treatment, rather than erecting one building after another, is not a universal one by any means.

And finally, there is the item of adequate financial support. The late Oscar Hammerstein once said that, "Money isn't everything unless you don't have it." Without plenty of money for adequate salaries for staff and proper facilities for patients we are fatally handicapped. With adequate budgets we are on the spot to prove that our ideas about effective treatment are valid. As we embark on newer and more expensive procedures, we must find more economical, yet satisfactory, ways of caring for those persons whose problems put them beyond the possibility of dramatic recovery. Even if we do live in an "affluent" society, we cannot afford to meet all the requests, however worthy each one may be, that may be made for social betterment. We who care deeply about the plight of the mentally ill and believe in the possibility of preventing illness and promoting health must be especially careful not to endanger our claims by promising too much and accomplishing too little.

In our struggles to make ourselves understood we occasionally encounter criticisms that we must be pretty inadequate or even stupid because we cannot measure accurately what we have been doing. There is even the inference, as I let my paranoid tendencies prevail for a moment, that people with good minds do not go into fields of study which abound in so many uncertainties. Research which imitates procedures current in the natural sciences seems to rate higher than that which deals with the vast sprawling masses of data that seemingly defy measurement because the variables are so numerous and indistinct.

By a variety of measures we keep our morale intact. Some wag has said that psychologists measure unimportant variables carefully; psychiatrists measure important variables carelessly. My own morale is boosted by encountering discussions by my favorite authors on this theme. Among my favorites is Whitehead. In a discussion[1] of the general character of human knowledge, he speaks of the division of knowledge into certainty and probability. He cites Plato as having given "an unrivaled display of the human mind in action, with its ferment of vague obviousness, of hypothetical formulation, of renewed insight, of discovery of relevant detail, of partial understanding of final conclusion, with its disclosure of deeper problems as yet unsolved." Yet Whitehead said that Plato "failed to make clear what was certain; and where he was certain we disagree with him." An attempt to fix exact meanings on phrases used in almost any discipline means that the beautifully organized knowledge "goes up in smoke." Yet pure skepticism cannot replace the lack of certainty. "Complete skepticism involves an aroma of self-destruction."

In simpler words, we who deal with the vast problems of mental illness and health must continually condition ourselves to uncertainty without becoming unhappy about it. Our stabilizing influences are more akin to belief and faith than to scientific proof and reason. Yet our plain duty is to bring more of the material with which we deal into a form which permits reasonable certainty.

And now what can we do on a national scale, as well as in our own communities, that will make possible earlier as well as better care for those who become handicapped by their emotional conflicts? It is obvious that no simple solution is in sight. A short time ago I reviewed the proceedings of the First International Congress on Mental Hygiene held in Washington just thirty years ago. Practically all the general principles we accept readily now were most clearly expressed then. The promise of good results in the future, if only the proper research could be done, was implied then as our speakers imply it now. But have we really made any progress?

Orville Brim, a very capable sociologist, stated recently that the beneficial results of psychiatry have yet to be demonstrated, but until we do know more about the value of both preventive and remedial services, both types of programs must be maintained. For some reason or other, many scientists and newspaper reporters seem to take delight in emphasizing how vague our results are, and in implying that we would all do better to ignore the whole problem of mental disease—or at least, that it

[1] *Whitehead, Alfred N., American Essays in Social Philosophy, edited by A. H. Johnson, New York, Harper, 1959, pp. 160-164.*

an emotional reaction I often get on reading their accounts. But, of course, neither they nor we think that we should or could stop doing all we can to prevent and treat disease, evidence or no evidence.

As I see it, we have made progress. An examination of public attitudes toward those in emotional distress, whether in schools, colleges, law courts, churches, or wherever, shows a much higher level of understanding of emotional problems than was evident thirty years ago. Furthermore, those persons who have grown up in communities with enlightened attitudes toward emotional disturbances and their alleviation are more prone to support modern programs than are those who have grown up without exposure to such points of view. In colleges, we see this principle shown in the way students accept the need for psychiatric help as compared with the much more conservative attitude of their elders, whether parents or faculty members. There are, of course, many exceptions.

Our task is not only to develop the best possible educational programs, each one working in his field of competence, but also to study the methods and results of those programs in such a way that when one person or group achieves a real "breakthrough," other groups may adapt the effective methods for their own use. I see no alternative to a comprehensive attack on indifference, ignorance, or outright opposition to promotion of mental health principles wherever they may occur. If we are criticized for being overconcerned, for having a missionary spirit, or for letting our zeal for action go a little beyond our scientifically proved knowledge, I don't think we should be too sensitive about it—just admit there is some truth in the allegations and go ahead with our efforts to improve the lot of the emotionally and the mentally ill.

It is now fashionable to decry the effect of talks to groups about these problems. With this position I strongly disagree. I do agree that poor talks by poor speakers to poorly chosen audiences may be worse than useless. Given favorable circumstances and effective presentations, however, such talks may well serve as preludes to constructive action.

Psychiatrists and their colleagues are presumably expert in their ability to promote communication between individuals. However, they are notoriously ineffective in understanding the subtleties of mass communication. The public relations of psychiatry is, in my opinion, in a sad state and we need to pay much more attention to it. Educational programs that bring us in close contact with the sentiment of people of all classes go far to help us realize what we are doing that is effective and what ineffective.

Educational programs such as I have envisaged should be of long duration, continuously revised, and promoted by all sorts of measures, formal and informal. In fact, some of the informal and serendipitous efforts may be the most rewarding of all if those concerned with promoting the program are thoroughly aware of what they want to accomplish and how their efforts appear to others.

Among the groups that are likely to be most cooperative in such educational endeavors are the organized volunteers, pastoral counselors, service clubs, women's clubs, school clinic personnel, family service agencies, and church groups. Approaches to private physicians, medical societies, judges, court officers, and police officials may also be very rewarding, but the disastrous effects of misguided efforts in these approaches must always be kept in mind. •

Controlling Bodies

Discussion Leaders:

JOHN J. BLASKO, M.D., and STEWART T. GINSBERG, M.D.

Controlling Bodies incorporate government agencies, legislative bodies, proprietors of voluntary and private hospitals, trustees, budget directors, financing groups, the courts, and the police.

PARTICIPANTS CONCERNED with groups which exercise some control over the policies and practices of mental hospitals spent most of their time talking about financing groups, with emphasis on state legislatures, probably because the majority of the discussants were state hospital people. However, the "four levels" spelled out by one group could, with some modification, be applied by private and Federal hospitals to their own specific boards and agencies.

Educating financing bodies, specifically legislatures, is a full-time responsibility, and must be met on four levels if financing is to be adequate and realistic: work must be done with the Governor, with the legislature,

Ten Tips to Support of Community Services

1. Enlist broadest possible support.
2. Get all health workers on your side.
3. Get okay from medical society.
4. Get to the political boss.
5. Tackle question of costs.
6. Emphasize rewards.
7. Overcome objections.
8. Use all media of communication.
9. Plan your timing.
10. Be flexible.

with the various related professions, and with the general public.

The attitude of the Governor, especially in a period of public apathy, can be the catalyst that provides the climate for effective development of a psychiatric program in a state. He can pace the legislature to a positive program, and this insures that the public will be made aware of the need for such a program. Caution is needed, however, lest the Governor become too symbolic of program motivation. Efforts must also be directed on a very broad front, otherwise a change in administration may lead to curtailment or even to abandonment of the program.

PERSONAL ACQUAINTANCE IMPORTANT

The superintendent and other members of the hospital management group should know the Governor personally, and have an understanding of his complete program. Likewise they should be thoroughly conversant with legislative committees—permanent and interim—be acquainted with the executives of employee groups, with labor management leaders, with the personnel of individual "helping agencies." In this way, the hospital representatives will be familiar with the individual strength and weaknesses of many key people, as well as with their potential interest and motivation in mental health matters.

On the professional level, the use of all the multidisciplinary organizations in the mental health and other health fields is immensely valuable. If organized medicine and general hospitals are well-informed about the mental health program, much support may be enlisted, especially from general practitioners and from numbers of other nonpsychiatric members of the medical profession.

One danger in dealing with financing and other controlling groups is to oversell the potential of a mental health program. Yet there is need for intensive and selective justification of the program from both the economic and the social viewpoints.

In one state, the legislature has been presented with two elements needed for a long-range program. One element is the need for better physical facilities for the "continued-treatment" patient, who will not benefit much by intensive treatment; the second is the need for enriched staffing to give better intensive treatment to new patients. Taken together, these elements of a long-range program would lead to handling more admissions, but leave fewer patients permanently in the hospital. Apart from social and humanitarian considerations, this would save the state 100 million dollars over a 10-year period.

INTERMEDIARIES NEED INFORMATION

Intermediaries, such as parents' groups or mental health societies, can help sell a program to the legislature only if they are well-informed and sympathetic with the hospital's objectives and treatment philosophy. Armed only with good will and ignorance, such groups may inadvertently harm the program. Likewise, legislative committees, such as Public Health, Finance, Ways and Means, and so on, may adversely affect the program if they are ill-informed about the hospital. When legislative committees and others actually come to the hospital, and are able to see and discuss the physical conditions and the treatment they have witnessed, the effect is usually positive and dynamic. For the same reasons, the Governor and the budget director, with their staff, should be encouraged to make personal visits to the hospital.

The image of the large state hospital held by the public has much effect upon its support of programs. Correctional and juvenile programs in the same department can detract from and adversely affect the desired image of the psychiatric institution as a treatment facility, rather than as a custodial catch-all. Even the name of the public hospital can be an important symbol, and if a name-change could effect a positive impression, it should be seriously considered.

QUESTIONABLE COMMITMENTS

Commitment laws do not always correlate with sound treatment philosophy, and there have been instances where such laws forced a patient into the hospital when admission was "both unwarranted and unwise" from a treatment standpoint. Commitment laws need modification to insure medical and legal collaboration prior to commitment. Where the judge is forced to act unilaterally or only with the help of a general physician, there are often questionable commitments. To avoid such situations, some agencies have set up observation and screening procedures. In certain areas where mental patients come initially under the jurisdiction of the police, psychiatric consultation has been provided to the police department. Orientation of police officers is desirable, so that their role may become complementary rather than opposed to the treatment process.

The policies of the office of the state commissioner of mental health, or its equivalent, were considered extremely important in the development of a good mental health program. This office should serve as a catalyst

rather than as a directive agency. Programs should originate in the hospitals, together with the necessary budgets, and the central office and the state budget director should support these programs.

FORMULATION OF GOALS

A big difficulty is the lack of a clearly established goal by hospitals and their central offices. Whether this goal is expressed as "good patient care," "reducing the hospital population," "a well-rounded program," or "rehabilitation," it must first be clearly formulated, then be made known to staff and public, and a technique for its implementation be outlined.

Once the goal is established and the program delineated, it is important to give the public an accurate picture of existing conditions, pointing out deficiencies as well as good points in the treatment program.

In dealing with the public, it is essential to single out key people who strongly influence public feeling and opinion. Here it is important to use practical, human illustrations, and good specific examples rather than "professional double-talk" to describe program needs.

Next comes coordinated mobilization of all the forces in the state, including the legislature, the Governor, and the general public. This can be accomplished by various means such as the use of the public information education, and communications media—newspapers, magazines, and local radio and television. This program is best carried out by a full time staff member, who will also assist mental health associations, legislative groups, and voluntary agencies in preparing news releases, speeches, and so on. Talks before parent-teacher associations and other community groups are properly a part of such a program, as are hospital visitations by judges, ministers, medical students, volunteer agencies, and other legitimately interested citizens.

Such a carefully planned approach—close cooperation between state authority and hospitals to formulate a goal and indicate techniques of implementation, and subsequent broadly-based attempts to bring the program to the attention of all important segments of the public—cannot fail to influence all the forces in the state, including the Governor, the legislature, the financing groups, the courts and the police, and the general citizenry. Once this influence is felt, all of the controlling bodies can better play a part in obtaining appropriate treatment for patients.

Professional Bodies

Discussion Leaders:

HARRISON S. EVANS, M.D.
J. B. BOUNDS, M.D.
DAVID F. VAIL, M.D.

Professional Bodies include referring and consulting physicians and agencies, as well as those to whom discharged patients are referred, and psychiatric and other mental health professionals who provide services to patients.

DESPITE THE NATIONAL TREND toward a higher admission rate coupled with a lower hospital population, discussants recognized that many problems still exist, and urgently worked toward finding solutions. They asked such questions as: Are the apparent successes attributable to better inpatient treatment, or to better communication with the community? Are we assuming that everybody understands what we are saying, or are psychiatrists and their helpers inclined to use esoteric language? Why, specifically, does there seem to be a greater communication difficulty between hospital psychiatrists and other physicians than between hospital people and social agencies?

The three groups discussing professional bodies spent more time exploring their relationships with general physicians than with any other single group. The majority of referrals are made by general physicians, and much is asked of them in the way of assistance before and after hospitalization. Other referring groups discussed included the courts, public health nurses, and health officers, and much time was spent in exploring the services rendered to the patient by social workers, nurses, health officers, and family doctors.

General practitioners are practical people. They want to know specifically what can be done for a particular patient. It is no use making general statements that mental health services will reduce mental illness, that sex-offenders are psychiatric problems. Physicians want to know what they personally can do, and what is expected of them. While it is difficult to give an unoriented physician information as to how a psychiatric patient should be handled, we cannot simply send his patient back, with the statement that we can do nothing more, and with no recommendations as to his needed course of action. Unless we have something concrete to give him in the way of information, we cannot expect much help from the general practitioner.

DANGEROUS EXTREMES

There was some feeling that the private practitioner feels superior to the hospital psychiatrist, who in addition sometimes labors under the disadvantage of having to tell family doctors, families, and the public something which they do not like to hear. Both these factors will engender hostility. The hospital psychiatrist must tread carefully between the extremes of being apologetic because he cannot promise to "cure" the patient, or, on the other hand, of making promises which cannot be kept.

Because the average general physician was trained at a time when psychiatry played a very small part in his curriculum, he finds it difficult to work with psychiatric patients. If he does have some success, however, he may come to feel that he too is a "psychiatrist"—an attitude which will lead to the deprecation of psychiatry as a specialty. Moreover, psychiatrists themselves apparently lack the ability to put over information to their medical colleagues as well as to the general public.

Various methods are used by mental hospitals to improve communication and therefore cooperation with general practitioners. These range from entertaining the local medical society at the state hospital once a year, to carefully designed training programs for these practitioners at hospitals or psychiatric centers. Such programs enable them to take what is in effect a postgraduate course in psychiatry. (The joint work of the American Psychiatric Association with the American Academy of General Practice endeavors to encourage this type of program.)

There are, of course, all degrees of endeavor between these minimum and maximum efforts. A psychiatric service in general hospitals is valuable because it serves to increase communication between psychiatry and other branches of medicine. Psychiatrists in private practice, if they can be induced to work as part of the community services, can do much to assist the general practitioner by offering solutions to particular problems, thus acting more or less in the role of consultant. Private psychiatrists can also be immensely helpful if they are invited to attend seminars with general physicians.

Some mental hospitals find it useful to invite the family doctors to make professional visits to their own patients who have been hospitalized and to continue any necessary physical treatment. This not only teaches the doctor psychiatry somewhat indirectly—by osmosis if you will—but also familiarizes him with hospital procedures and makes him more secure in his approach to the family. He can, as a result, greatly increase their confidence and understanding of the psychiatric patient by describing at first hand the situation in which the patient will find himself in the mental hospital. This tends to reduce ignorance and rejection both of mental patients and of hospitalization.

Again comes the question of the image of the public mental hospital which needs considerable improvement. It must be presented, if this can be done honestly, not as a custodial institution for the "incurable," but as a *hospital*, which undertakes active and often very effective treatment, as well as teaching and research. If a hospital has this kind of reputation, the general physician will no longer be reluctant to be associated with it. He will, on the contrary, seek the professional prestige of being known as a welcome and productive visitor.

But it is not enough to ask physicians into the hospital. In turn, hospital psychiatrists must go out into the community. Only thus can they honestly evaluate and meet its needs, and seek solutions to its problems. The hospital can expect to get consideration and help with its own problems only if it first attempts to satisfy community needs. Too often, for instance, the hospital lacks information about the patient's premorbid adjustment. This the family physician will willingly supply, provided that he in turn is informed about the diagnosis, the treatment possibilities, and the prognosis.

Many hospitals have found the public health nurse a fine resource for obtaining preadmission information. This is difficult in some areas because the lines of authority are vague. Training programs for public health nurses and for health officers are found to be helpful in improving communications and developing some continuity in psychiatric care. The health officer can be a good entree into community resources, provided hospitals do not attempt to unload "problem patients" on him, but honestly work with him to iron out mutual problems. Social workers in the community with welfare or family agencies can likewise be a valuable source of information.

HOSPITALS AND THE COURTS

Referral by the courts leads to all sorts of problems, most of them based upon the fact that commitment and incompetency procedures still reflect reactionary ideas. Psychiatric observation is desirable *before* a court hearing, and social investigation should be done before the court makes a commitment to the hospital. The courts are sometimes tempted to send a person to the mental hospital for preventive purposes—for instance, in the case of some psychopathic personalities. Since the community rejects such people, the hospital is expected to hold them for the protection of society.

What should be the role and function of the mental hospital in promoting collaboration with the professional community? Under present conditions, it is generally agreed that the hospital has to assume leadership, although a case can be made for involving the local mental health association to assist in motivating the professional community to learn more about the hospital program.

Should leadership be given by direct service, or indirectly, by promoting service on the part of the community professionals through consultation and similar techniques? The consultation role furthers the aim of providing service, and at the same time serves to educate the professional groups involved. In terms of efficiency, it may be desirable for the hospital to provide direct service, such as for example, diagnosis, even though this practice could exclude the community agencies. As so often happens, the middle of the road may prove to be the most practical route: diagnosis and other services can be provided by a community agency, with the consultative guidance and assistance of the hospital. Finally, is collaboration, direct or indirect, better accomplished through the medium of the individual case, or through such general techniques as the sponsoring of workshops, training sessions, and tours at the hospital?

THE VITAL TIMES

Whatever the specific methods used, there is agreement that the state hospital should have significant communication with the community professionals at four vital points in the patient's illness:

1. The point at which case discovery and screening take place;
2. The diagnostic process;
3. The point at which referral for community service is made;
4. The treatment process in the community.

It is obviously essential for the hospital staff to be knowledgeable about the sociological, economic, and political structure of its community, and of the totality of the professional resources available.

This leads to an obvious conclusion—that every psychiatric institution should be in reality a mental health center for its community.

Plainly this ideal is barely in the blueprint stage as yet, but a number of programs in various parts of the country point to the fact that honest endeavors are being made to implement this idea. In Connecticut the hospitals take leadership by trying to enlighten the family doctor as to diagnosis and treatments, and by means of medical society meetings and personal contacts. Kansas City has a psychiatric receiving center which gives advice and counsel, with a public health nurse assigned to develop continuity of medical care. Health officers attend an annual two-week seminar in mental health problems.

Chicago has a community service which undertakes psychiatric as well as other medical referrals; area psychiatric consultants will work with welfare agencies and accept their referrals. In Seattle, the hospital is attempting to act as a coordinating agency by having its head social worker operate closely with referring agencies, and helping to work out placement of patients after discharge. This program is in its early stages and there are many problems.

In Ohio, the mental hospitals hold meetings with local social agencies, medical groups, and mental health clinics, the personnel of which may request the hospital to review cases and recommend programs. There is a

Treatment Experiences with Professional Bodies

1. There is too great a tendency to commit patients because the professional body, whether an individual physician, an agency, or a legal facility, is faced with a "problem" that may not be primarily medical but for which the hospital is used as a "court of first resort." This would be a satisfactory approach if the commitment of the patient were not the first step. Too often no effort is made to find an alternative.

2. There is a widespread tendency on the part of physicians and courts to make promises to patients in order to facilitate admission, such as telling them the type of treatment they will receive, how long they will be hospitalized, etc., thus putting the medical staff of the hospital in an impossible position after the patient is admitted.

3. There is an increasing tendency to treat serious psychiatric illness with the new drugs, thus putting off a period of hospitalization that the patient will eventually need. This constitutes a problem because full hospitalization is occasionally avoided, but purely pharmacological treatment is a trap for many physicians not experienced in psychiatric matters.

4. Complicated commitment laws tend to prevent early admission of cases for which early hospitalization is most indicated, namely, of the acutely psychotic patient.

5. Too often both family and family physician are uncooperative in accepting hospitalization for seriously ill patients.

6. In many areas, the health officers (or their equivalents) are markedly complicating the process of psychiatric treatment by lack of knowledge about this aspect of their job. Many discussants have been unable to activate their health officers to admit patients who obviously need hospitalization; others complain that the health officers in their area are too prone to unnecessary hospitalization which results in the patient's discharge within 24 to 48 hours.

7. Several discussants pointed out the persistent criticism from public groups that psychiatrists who address them cannot project themselves to the laity, do not "get through" because they have moved too far away from the typical beliefs and anxieties of the public.

8. Hospitals do not do enough to encourage volunteer groups and do not sufficiently utilize them when they do exist.

free flow of communications between hospital staff and community physicians.

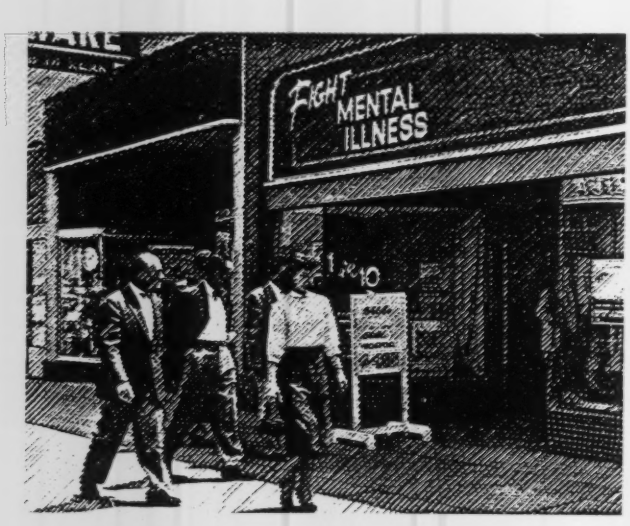
Washington hospitals hold meetings of groups from rehabilitation agencies to try to solve both problems of communications and problems specific to each attending agency. The theory here is that, if all agencies could coordinate their efforts, the period of hospitalization would be shortened. While this hope was not realized—apparently there was too much communication between too many people—the program did help by familiarizing all hands with each other's problems. At the present time the agencies are working to help the hospitals set up orientation programs for public health nurses and social workers in welfare groups.

California, hoping to put community programs on a sound financial basis, matches local with state funds; general hospitals are building psychiatric facilities and establishing psychiatric open clinics. Training programs for all groups concerned with mental health are being set up in the hospitals. Public health nurses spend a full week getting orientation, and children's units are being established to which juvenile courts can refer their cases. Teachers attend talks about the behavior problems of children. In southern California, judges have been persuaded to send all geriatric cases to nursing homes or sanitariums for a month-long period of evaluation before definitely deciding they require commitment to a mental hospital.

Community Service Bodies

Discussion Leaders:

ROBERT C. HUNT, M.D., and MRS. ANNA T. SCRUGGS



Community Service Bodies embrace such resources as mental health associations, service organizations, and civic organizations.

AFTER THE USUAL STRUGGLE with definitions, one group decided that "any community service activity which centers around the patient and includes the participation of the families, of the community, and of the hospital staff should be deemed a treatment activity." The subsequent discussion was based upon this formulation.

Both group discussions seemed to have a note of optimism and encouragement, and there was a general impression of fairly good liaison between the hospital and community. Even the problems posed were questions for which answers could be found, rather than difficulties which seemed insoluble.

It is the responsibility of the hospitals to provide, at the local level, direction and guidance to community organizations, in order to prevent overlapping and duplication of services which lead to discouragement and loss of interest. In the end the patient will benefit most through two-way cooperation. In other words, the hospital must offer service to the agencies, as well as the agencies giving assistance to the hospital.

Agencies mentioned as cornerstones in the program included state mental health associations, the Red Cross, church organizations, women's auxiliaries, men's service clubs, Chambers of Commerce, veterans' organizations, various civic and fraternal groups, commissions for the blind, Alcoholics Anonymous, and associations for retarded children. Hospital relationships with these groups are good, and the task of the hospital is to devise ways in which productive use can be made of the support they offer.

A specific example of good cooperation at the local level is the screening by the Red Cross of all volunteers. In one community, the Red Cross even screened those who wished to work as individuals, rather than be identified with any specific organization.

But the hospital also has a responsibility to provide good volunteer orientation, centered around the needs of individual patients. The formation of women's auxiliaries in mental hospitals, patterned after those which operate successfully in general hospitals, is valuable. The utilization of the services of young people, either as volunteers or as part-time workers, has the added benefit of increasing the understanding of the younger generation of the needs of mental hospitals and their patients.

Most hospitals have resident chaplains, but much more could be done by providing additional contact between the patients and dedicated church groups on a nondenominational basis.

There is great need for improvement in the liaison between the hospital and such local news media as press, radio, and television. State mental health budgets should provide for a good public relations officer at each state

institution; if, in addition, the hospital has a paid director of volunteer services, these two people together can provide a team approach to acquaint the community with the hospital needs, as well as provide the avenue of approach from the community more directly to the patient.

Every state hospital is faced with the problem of the lack of adequate funds to provide a complete program of care, and it is therefore their duty to assume a more forceful role in encouraging or soliciting help from community organizations. Moreover, not all hospitals are doing all they might do, even with their limited staffs. The question then is how the hospital staff can become a more integrated part of the community, in order to secure the needed help, and at the same time, serve the agencies themselves. Basic approaches include:

1. Encouragement of hospital personnel to join community groups in order to foster better understanding of the hospital in the organizations to which they belong.
2. Recognition by the states that the hospital is no longer an isolated community within itself, and the provision of a living wage for employees so that they may reside in the community rather than on the hospital grounds.
3. Willingness of hospitals to open their doors and where feasible make their facilities available to the community.

Questions, at least partially unanswered, or to which new and different answers would be helpful, include:

(a) Should the orientation of the community be to the hospital, or to the patient?

(b) How can we establish a reciprocating system among community, patients, and hospital, rather than concentrate only upon what the hospital can get out of it?

(c) How can we utilize both altruistic and nonaltruistic motives in introducing the community to the hospital?

(d) How can we involve community bodies in eliciting what can be done *for* the patient rather than *to* him?

(e) How do we bring about a participating working relationship between the hospital, the patient, and the community? (The problem is one of strangers trying to understand each other.)

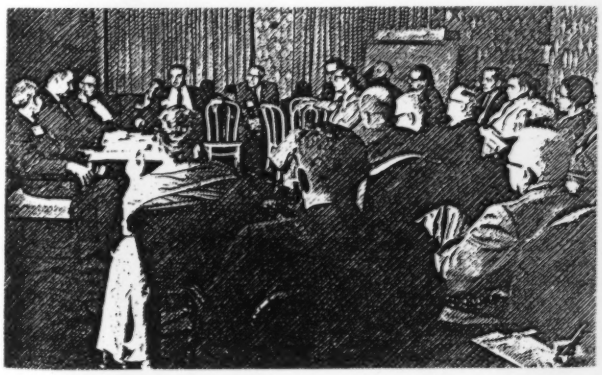
(f) Where does the leadership come from, and how do we create it? Is it entirely in the hospital, in the community, or in both?

To answer these questions, the "we/they" relationship often held by the hospital must be overcome. While there should be no "curiosity" visits allowed in the hospitals, legitimate visitors should be encouraged. Patients themselves can do much to further understanding by acting as hosts to such people; this is one way in which the voice of the patients can be heard by the public.

Positive contributions being made by community service groups include their help in securing financial support for community mental health programs in cooperation with the local mental health association; the work done by these agencies with nationality groups and labor unions; the orienting of high-school and college students to mental hospital programs; and the sponsoring of individual patients by community service groups. •

The Scientific Community

Discussion Leaders:
ROBERT H. DOVENMUEHLE, M.D., CLYDE MARSHALL, M.D., and PAUL PENNINGROTH, M.D.



The Scientific Community covers the A.P.A., the A.M.A., and other medical associations, county medical societies, research and educational groups, and publishers of professional and educational journals.

TWO OF THE THREE GROUPS engaged in discussing the scientific community found some difficulty in defining their task, with the result that one discussed mainly national organizations, such as the American Psychiatric Association, the American Medical Association, and others, while another concentrated most of its attention upon local medical societies and other local professional associations. The third group, apparently having no such difficulty, covered both areas of discussion. All three groups were in general agreement about the nature of the problems.

Plainly, solutions must be sought both at local levels and through national organizations. Both levels of the "scientific community" can do much to promote improved patient-care.

Among problems identified are the many conflicts, for instance, of interest, theory and practice among the various medical specialties, and also among members of different mental health disciplines. There is much confusion about areas of responsibility and appropriate func-

tions, which must be clarified by professional people themselves at all levels.

Related to these conflicts are various professional attitudes which adversely affect the treatment of psychiatric patients. Psychiatry has been for too long the orphan of the medical profession, seeming to nonpsychiatrists to be too diffusely connected with other medical specialties and with general medicine. One reason is that university medical schools and mental hospitals have not developed sufficient communication; not only is there too little psychiatry taught at the undergraduate level, but even residents in a university setting treat but a handful of selected patients, and rarely experience the responsibility of handling several hundred, quite unselected, in a large hospital-setting. Medical schools seem poorly informed about the special needs and problems of mental hospitals, with the result that students and residents are discouraged from developing any interest in them. Similarly there is a need for public health and mental health groups to understand one another's different points of view.

Recruitment of young men and women into the various disciplines related to mental health is an urgent matter. The brightest of the medical students are not attracted in sufficient numbers to psychiatry as a specialty. Social workers, traditionally trained to be somewhat dependent upon a supervisor, shrink from the responsibility of handling a large caseload with the minimal supervision offered in state hospitals. The specially trained psychiatric nurse doesn't want to become so involved with the administrative routines of a large hospital that her direct work with patients is sacrificed.

SOCIALIZED MEDICINE?

Another difficulty is the attitude taken by some physicians that mental hospitals are practicing "socialized medicine." This type of state medicine has been in existence in the United States for at least two hundred years. Needed is a healthier understanding of the necessity, within our existing social structure, for a state mental hospital system, and of the type of medicine which must be practiced in such a setting. A suggestion was advanced that the A.P.A., the A.M.A., and the American Academy of General Practice might work together to develop a better understanding among general physicians of the true nature of state hospital medicine.

Medical societies, feeling threatened by possible encroachment by state services, are not inclined to be especially cooperative with mental hospitals and clinics. Relations between the clinics and hospitals themselves are often poor. Roles and functions between psychiatry and allied disciplines are poorly defined, and even individual psychiatrists have difficulties, involving personal value systems, status differences, and the amount of emphasis each is inclined to place on the welfare of his patients.

There are many possible solutions to the problems enumerated, some of the most effective being through action by national associations. Recognizing the need for discussion about some particular problems, such groups can bring together the people who can contribute solutions to a better understanding. The A.P.A. Mental Hospital Institutes are an example of this. Local meetings can likewise be arranged to provide for an exchange of information and opinions.

The scientific community, in any of its manifestations, can publish and distribute helpful material. Newsletters from sections, from mental hospitals, or national bodies can be helpful in acquainting others with the activities in hospitals, and can provide guides and instructions to state hospital staffs. An example of a useful national publication is the A.P.A. hospital journal, MENTAL HOSPITALS, the February issue of which contains the report of the annual Mental Hospital Institute.

MORE SERVICES NEEDED

But it is not enough for the A.P.A. to hold Institutes and to publish material. It should make its services available to aid groups in the problems which confront them, and to provide whatever consultation is indicated. (The consultation should be initiated and made available, but not, of course, imposed on hospitals.) One group felt that the A.P.A. had made a serious error by discontinuing the services of the Central Inspection Board. Now the mental hospital is in the position of being judged by criteria designed for general hospitals, standards which are basically unrealistic for the majority of large state hospitals. Accreditation by unrealistic standards will re-

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sult in the destruction of proper recognition by psychiatry.

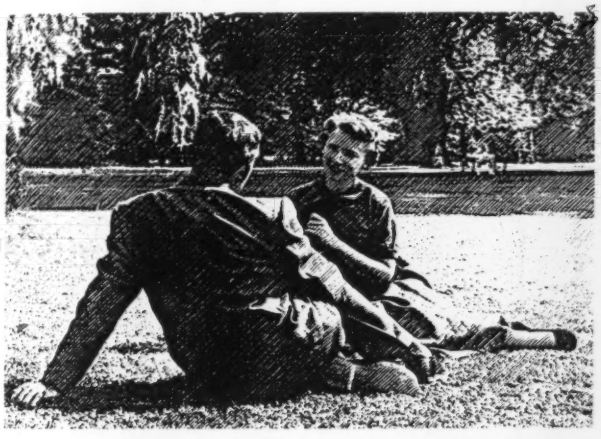
National professional organizations can assist in recruiting personnel into the mental health professions—for example, by helping junior colleges organize nursing programs, and by encouraging hospital nursing schools to emphasize the nursing needs of mental hospitals. if needs are pointed out by a responsible national body.

Joint planning on the national level between various professional groups can do much to encourage or even conduct research to determine why similar practices seem to have varying results. All too many good research projects are ignored, or never undertaken because of the difficulty in obtaining publication of the results. Teaching standards too could be lifted if national organizations would take the leadership.

The Patient-Community

Discussion Leaders:

NELL T. BALKMAN, R.N., and T. J. BOAG, M.D.



The Patient-Community refers specifically to the other patients with whom a patient is associated either in or out of the hospital.

CURIOUSLY ENOUGH, staff members in mental hospitals are often completely oblivious of a very obvious fact: that whenever a group of people, including mental patients, are placed together in limited physical surroundings and in a particular situation, a social system develops. The reports of sociologists who sit and observe ward interactions are frequently a revelation to the staff. Lines of communication and authority exist among the patients themselves which are apparently unrelated to the overt social system set up by and within the purview of the staff. Yet it is impossible to discuss the patient-community in a vacuum, so to speak, because relations with and among staff members greatly influence its nature.

Many factors, of course, influence the patient-community, among them the physical surroundings in which the patients live; the size of the ward; hospital policies regarding visits, clothing, and wearing of personal jewelry; and whether the ward is open or closed; as well as the attitudes, spoken and unspoken, of the hospital staff toward the patients in terms of hopefulness, respect, friendliness, and so forth.

The effects of the patient-community upon the course of the illness of an individual patient may be positive or negative. On the positive side, there are very definite therapeutic values, often unsuspected by the professional staff members, who take credit to themselves or their therapy for a remission; on the other hand, relationships within the special community of patients can be extremely damaging.

One of the major causes of a damaging situation seems to be the patient's loss of his own sense of identity and his tendency to assume roles which are not genuine, but are projected upon him by other patients or by the staff. The manner in which he was admitted, and his initial orientation to this strange, impersonal institution will be significant. If he is forced to surrender his wedding ring, his watch, and other personal effects, this will contribute to his loss of a sense of identity and of personal dignity.

Being called by his first name may assail his self-respect, although this may have a good effect upon some and a bad effect upon others. Staff members who increase his dependency by doing things *for* him rather than *with* him, and defeatist attitudes toward him personally or toward the group in which he is placed also serve to debilitate his ego-strength. Along with such weakening influences comes overdependence upon the hospital, which may be, in many respects, quite a pleasant place.

THE PATIENTS' GRAPEVINE

In the end, the patient becomes a full member of his ward-community, and like a prisoner, will be ready prey to the contagion of false rumor, defeatism, and the unreliability of the grapevine system of communication between patients. "If you go to electroshock on Wednesday, it means you will be here for six months"—this from a fellow patient is more readily believed than the truthful statement of the nurse or doctor. "Patients who have been in here a long time know what goes on; they know the routine. The doctor or the nurse just tell you something to keep you quiet."

Dangerous alike to the weary, gullible old-timer and to the anxious newcomer are those fellow-patients in good contact, who talk sensibly and practically. A man can rely on these patients—even when they remark quiet-

ly; "If you let them take you up for treatment, you'll come back deformed."

The groups of patients who are irritable and hard to get along with cause trouble and also suffer themselves in the patient-community. They have been rejected on the outside; they are rejected by fellow patients.

Feelings, attitudes, atmosphere, and ideas of all kinds are communicable. They can be described as endemic—these sick ideas which go through the air. These are the forces which staff members must combat, but of which they are all too frequently unaware.

We are not quite clear, for instance, what proportion of patients are susceptible to the influence of others, or how patient-to-patient relationships in a general hospital differ from those in a mental hospital. The same feelings, anxieties, and uncertainties are present among general hospital patients, but seem to be demonstrated to a greater degree by patients in mental hospitals. The public, while more or less aware of the goals of a general hospital, is unclear about the goals of the mental hospital; a stereotyped and false image still prevails. Thus, within the social structure of the mental hospital ward, there is greater uncertainty, which is immediately reflected in the patient-to-patient relationships. To remedy this, can we not be honest with individual patients as to their prognosis and possible length of stay in the hospital, as we are with general hospital patients? Cannot the psychiatric nurse, with proper background and preparation, be of more assistance to the psychiatrist in interpreting to the patient his present status and future prognosis? The patient wants to know, and is indeed asking for information. The difference between the general and the mental patient may only be one of degree. Everyone who goes into a hospital feels somewhat helpless; his role is passive—he runs the same risk of losing his identity. Yet the general hospital patient, reinforced by reliable information from his doctor, is not so subject to false rumor from fellow patients.

ADVERSE FACTORS

Thus among adverse factors can be listed: misinformation given to patients by others about ward activities and treatments; the interpretation of one another's symptoms (like two old ladies, one with diabetes and one with heart trouble, swapping medications); threats and rumors; the feelings of withdrawn and depressed patients toward disturbed and hyperactive ward-mates; the anxiety of some increased by a large number of patients on the same unit; rejection by community and family; length of time in hospital; and an admission ward with all kinds of patients, regardless of the degree of their illness.

Contributing to these adverse patient-to-patient relationships are the basically unhealthy attitudes of the patients themselves, of their families, their communities and even of the hospital staff itself toward mental illness; the therapeutic needs which are not being met because of the physical and emotional environment; the distorted communication among the patient-community; and the poor orientation to the hospital.

The discussion leader recorded an interview she had set up with 27 patients before she came to the Institute. She had told them about this discussion topic and the task which had been assigned. The following expresses, in their own words, the patients' ideas of the negative factors:

1. Close confinement with other people.
2. To go home and before too many weeks have to return to the hospital.
3. Irritability and displacement of feelings on fellow patients when their personal clothing, etc., followed several days after their being transferred to another unit.
4. Patients that are nervous make other patients nervous.
5. In large groups, you lose your identity and not much attention can be paid to you.
6. Locked doors when you come alone to the hospital or come because you know you need to come.
7. Sicker patients being with patients that have improved.

This same group of patients presented the following comments about helpful relationships with fellow patients:

1. It has been very helpful by other patients letting me help them—teaching them to play chess, etc.
2. Greatest help is compatibility of the men. If they do not get along, the men become depressed.
3. To communicate with each other—we need more of this.
4. To not lose identity and be able to select good associates.
5. It's a prime matter of indifference because a person can be at home in a small village or they can be isolated on the streets of New York. It depends on the person's personality and reactions.
6. Small groups help you to know other people and to be known.
7. Patient Council—You've got somebody you can talk to that can talk to the doctor when you are not able to express your needs to him.

Some of the methods described by participants to combat deleterious aspects of the patient-community are endeavors to improve these situations described by patients themselves. One is the division of the hospital into small units, within which it is easier to recognize individual needs and to diversify treatment procedures and communications. Then there are the various attempts to structure group communications to avoid sick or unhealthy ideas, such as, for instance, patient-councils and similar groups. (In this connection, the terms "patient government" and "therapeutic community" came in for considerable criticism. Patients, it was said, never really govern themselves, and treatment responsibility must always be in professional hands. "Patient council" was suggested as a substitute term.)

In patient-groups, individuals can be encouraged to plan their own activities cooperatively, and to increase their sense of responsibility for self-care, recreation, or even for helping other patients. A disadvantage in the so-called "therapeutic community" is the emergence of over-aggressive leaders; to counteract this, it was suggested that staff guidance be ever present, even though it is somewhat covert.

interpretation both to patients and to relatives of the treatment goals as early as possible—even, if possible, before the patient's admission—will do much to break up rumor formation among patients, and to dispel excessive anxiety and hostility among relatives. Ward conferences are helpful, not only in answering questions, but in allowing patients to express their feelings. Among other suggested solutions were combining the rejected group of patients with the accepted—i.e. the "chronic" with the "newly-admitted active treatment"; smaller groupings of patients and socializing with the "rejected" in a group and individually, especially during the evening hours when these patients feel so alone; group therapy; psychodrama (role playing); consulting groups of patients as to how they feel the problems confronting them could be solved; continuous inservice training of personnel; volunteer contributions—invaluable since they bring the community to the patient; and the promotion of public education and support.

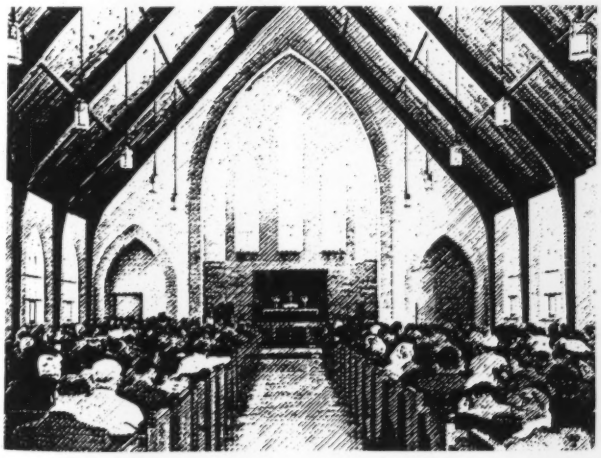
Nor must the contributions made by the patients themselves be overlooked; they must be actively encouraged. Among them are the group activities organized by patients, and the development of the patient-council into a responsibility-accepting body which helps make some of the ward policies and sees to it that they are carried out.

The principle involved is the importance of the patient having a part in the patient-community and sharing in the decisions made. The patient is the one who knows what is going on in a given patient-community. We (the professional staff) are in our ivory towers ordering, prescribing, directing, and the patients are doing just the opposite. They are conniving, asking for, and getting around, working one against the other; the aide is in the middle and does not know with whom he should identify. He either identifies in an unhealthy way with the patient, or in an unhealthy way with the staff member. So we have three worlds pulling in three different directions. We cannot work without the patient. He is the most important team-member and he is the one who is really the expert. He knows what other patients do at night, which nobody else knows because there is only one aide to 40 patients. The key problem is the resistance we run into of one patient being unwilling to "tell on" another. We have to overcome this idea and communicate to patients that they would really be relating information that would help. This is training the patients to be therapists. They learn to identify and feel for the other patient, discover what his problem is and how we can help. This is giving them responsibility in decision-making. This is truly patient-government and patient-participation. •

The Patient's Social Community

Discussion Leaders:

R. A. CLELLAND, and PETER A. PEFFER, M.D.



The Patient's Social Community takes in his family, his neighbors, his employer or school, his church, and other groups with whom he normally associates.

THE TWO GROUPS discussing this subject at the Institute found it extremely difficult to differentiate between treatment and aftercare as they are affected by this specific community body. However, they accepted the assignment as charged and generally solved the division of treatment and aftercare by centering their discussions around the persons or groups in the above definition who were most closely allied with the patient in the two phases. One group did suggest that the patient's family physician should have been included in the definition.

There seemed to be no general area of agreement concerning any considerable contribution by this community body to the obtaining of appropriate treatment. However, the mental health associations were credited with effective action in some sections of the country.

The patient, his relatives, and the hospital itself shared about equally in the blame for delaying or disrupting treatment, with the relatives being given a slight edge. Their refusal to recognize mental illness in a member of their own family; their fear of financial insecurity if the breadwinner must go to the hospital; their abandonment of patients in the hospital, were all cited as deterrents to effective treatment. However, both groups agreed that the hospital is responsible through default for most of these family attitudes, and that proper education and preparation of families prior to and during a relative's hospitalization could forestall many of the problems.

In pinpointing resources for informing the persons and groups in the patient's social community, the main role was assigned to social service as having the most frequent contact with the families. Other resources mentioned were the public health nurse, community social agencies as an extension of the hospital staff, the chaplain, the family physician, volunteers, and psychiatric teams working in the community.

MAINTAINING CONTACT

Discussion centered around ways and means of maintaining contact with the patient's social community during his hospitalization. Length of stay was considered to play an important role in this connection, since family contacts tend to deteriorate and even disintegrate if the patient remains in the hospital for a very long period of time. In England the family signs a patient into the hospital for only four weeks, the theory being that family contact is lost if the hospitalization extends over six weeks. Families may return the patient to the hospital, however, for such reasons as vacation, illness, or unexpected guests, and the hospital gladly receives them for these short periods. There are now some hospitals in this country who are readmitting patients for two weeks so that the family can go on vacation or be free to care for another member of the family who is taken ill.

Various modifications of visiting hours are being tried to encourage relatives and friends to spend time with the hospitalized patient. Many hospitals have rigid restrictions against visitors for the first ten days after admission, and this is believed by some to be a strong contributory factor toward the breaking of family ties. A case of "out of sight, out of mind," so to speak. Nurses and physicians were cited as the two groups most resistant to unrestricted visiting. Further, it was pointed out that many hospitals schedule their visiting days or hours at the very times when physicians are not available, and so the relatives never get a chance to talk to their patient's doctor. One hospital has solved this by setting aside one hour daily when all staff physicians are available to visitors.

The admission interview can actually set the tone for the patient-family relationship during the entire period of hospitalization. Generally speaking, it should be as pleasant and informative as possible and the emphasis should be on hospitalization as temporary. It was stressed, however, that caution should be observed against overoptimism and assurances to the family of ultimate "complete recovery." Many patients upon discharge still show residual disabilities and the public should be educated to this fact. The partial disability of the mental patient is no more crippling than the disability of the general medical and surgical patient who leaves the community hospital. It does not prevent him from exhibiting socially acceptable behavior or being responsible and amenable to further rehabilitation. It is important to point out to the family the numerous assets of the patient as opposed to his deficits. It is surely a gain when a patient is able to stay out of the hospital eight months out of twelve. (In this connection there was some feeling that mental hospitals should not show undue concern with statistics regarding readmissions.)

The public health nurse is receiving more extensive attention as a resource person in maintaining contact with the family and serving as liaison between the patient and the community. In one state, at least, she is notified at the time a patient is admitted to the hospital. She visits the family, interprets the hospital program, and stresses the importance of frequent and regular visits to the patient. Many hospitals are providing week-long orientation courses during which the public health or visiting nurse stays at the institution and may be assigned a case study. Others send clinical abstracts to the public health nurse so that she may be better able to interact with the patients' families.

Another approach is the formation of regional committees consisting of personnel from various mental health agencies. Members of these committees communicate with the family physician and other local agencies about the hospitalized patient and his family.

In considering means of educating and informing the patient's social community about his illness and about the hospital, mention was made of the regular news channels such as newspapers, radio, and television. Special note was made of the hospital-newsletter type of approach. This is a particularly good way for the institution to keep the relatives informed, stimulate visits to the patient, and generally help prepare his family and associates for his eventual return to the community.

VISITING ON THE GROUNDS

Family-day programs, where relatives and friends come and visit with the patients, picnic on the grounds, plan and participate in social events, etc., are becoming more and more common with the advance of the open hospital. The relatives recognize that patients need not be in locked wards and that the staff is placing trust in their patients. This has tremendous meaning for them.

Regular week-end visits home are a possibility for increasing numbers of patients through drug therapy. These too can be turned into a highly effective program for maintaining family ties. They are particularly important as a transition period where the family has reshuffled itself consciously or unconsciously to the exclusion of the patient. A word of caution was inserted about the need for explaining the use of drug therapy to the relatives. The patient who requires maintenance therapy is like the diabetic or cardiac who requires daily medicine. The relatives should be oriented to the fact that their patient is now a changed person who has responded to therapy.

The discussants agreed that all too often the hospital staff which is responsible for the patient's treatment knows far too little about the problems and stresses in his social community. Many times these problems and stresses arise after the patient has been hospitalized a considerable length of time. There are many reasons and causes for this and many factors must be considered; but in the end it is the hospital's responsibility to maintain contact by all the means at its disposal with the social community of the patients under treatment.

The General Public

Discussion Leaders:
WILLFRED BLOOMBERG, M.D.
WILLIS H. BOWER, M.D.
F. E. McNAIR, M.D.

The General Public is a heterogeneous group seldom in direct contact with the hospital and influenced mainly through mass media or word-of-mouth reports from others not directly involved with mental patients.

HOSPITAL AND PROFESSIONAL STAFFS are technical experts hired by the general public to care for its mentally ill. Thus, knowingly or unknowingly, the general public assumes a certain amount of responsibility for the treatment of patients in mental hospitals throughout the country. The question is how to increase the numbers of people in the knowledgeable category; the hopeful paradox is that if this can be done successfully, these people will cease to be members of the general public and become part of one of the specific publics more intimately concerned with the hospital and its patients.

There are several channels through which this conversion can be accomplished. Prime among these, of course, are the mass information media such as newspapers, magazines, radio, and television. Although some discussants objected that these media often distort and sensationalize material and tend to present the negative rather than the positive aspects of treatment for mental illness, it was pointed out that this is not always bad. Much progress has been made as a result of this kind of crisis-reporting. However, a person skilled in the use of mass media can serve a vital function on the hospital staff by establishing better channels of communication with the press, radio, and television.

Some discussion occurred as to whether the public relations approach is "overselling" the mental hospital. To avoid this, the public relations person must work closely with the superintendent and other top professional staff. Thus he can be aware of long-range program goals and strategy, and can use his communications skills to develop public support of these goals. One discussion leader stressed the importance of a superintendent's being convinced that a public relations person is necessary at his hospital before he approaches a legislative group to provide funds for the position.

Other sources of information to the general public include hospital employees and volunteers. Both of these groups must be given sufficient orientation to enable them to keep abreast of policies and programs within the hospital if they are to act as accurate sources of information to the outside community of which they are a part. Their contacts spread in ever-widening circles from their families, to their neighbors, to their friends, their friends' friends, and so on; thus they comprise an important factor in creating an informed or a misinformed public.

With the increase of the open hospital and the emphasis on rehabilitation, the patients themselves are becoming ambassadors of the hospital in their day-to-day contacts with persons in the community. Whether they are good or bad ambassadors depends primarily upon the wisdom of the hospital administration in conducting its treatment program.

THE PRIME INTERPRETER

Probably the one person who can best serve as intermediary between the general public and the mental health profession is the general practitioner. He has a unique opportunity to interpret the mental hospital to his patients and to convince them that inpatient care is only one phase in meeting the needs of the emotionally disturbed. More and more mental hospitals, realizing this, are sponsoring informative and educative programs for the general medical physician.

Mental health associations are also channels of information, as are other community groups which have some knowledge of what the hospital is trying to accomplish. Many hospitals are opening their facilities to such groups for monthly programs or meetings and intensive tours through the buildings. The speakers bureaus at various hospitals often provide the lecturer for such meetings, as well as for meetings of civic and other groups in the community. Staff members serving on speakers bureaus have an excellent opportunity to convert the uninformed general public to one of the knowledgeable specific publics.

With all the conversions, however, there will still remain a group of people who are not directly associated with the hospital or the patients and who, for one reason or another, do not wish to be. This is not to say that these people are totally unconcerned. Just as the person who buys Christmas seals has a stake in the treatment of the tubercular patient, so the person who never comes in contact with the mental hospital, but whose taxes help to support it or whose efforts contribute to it, has a part in the treatment of the psychiatric patient.

PREFACE

A. B. STOKES, M.B.
Professor of Psychiatry, University of Toronto, Canada

The Provision for Appropriate Aftercare: Hospital and Community Collaboration

Aftercare is defined as a program designed to maintain or strengthen the improvement attained by a patient during his hospital treatment and to increase his likelihood of making a good adjustment to community living.

ANYONE TAKING UP THE TOPIC of the discharged patient suffers the immediate disadvantage that he cannot make sense of his subject unless he refers to all that has gone before; it is true that at some particular point in time a patient leaving a hospital becomes a discharged patient, but in terms of a particular total process he is moving in a continuum of events relative to an illness. In a final analysis, illness is a breakdown in living; somehow, somewhere, someway, the particular person has become unequal to the efforts or tasks expected of him. He seeks help, or help is sought in his behalf, at first maybe from relatives and friends; later perhaps from employer; still later from pastor or lawyer or social worker or some such significant social focus of aid. At some stage in the search, this individual is referred to a doctor and thereafter becomes a patient with the connotation of illness.

The doctor-patient relationship thus established may be developed by mutual effort to the benefit of the patient without recourse to a hospital; but, if and when the patient is admitted to the hospital, the doctor is using a social institution for his medical purposes.

The hospital as a social institution is a fascinating study in itself. Of pertinence here are two very general statements: first, as medical technology developed with unforeseeable rapidity, the general hospitals tended to lose their earlier human social attributes; second, the psychiatric hospitals were unable to redress the balance out of technical, psychological, and sociological strengths. It is very recently that, from the older traditions of mental-hospital practice, these strengths have emerged in new guise sufficient to implement effective action. Psychiatry as a whole, whether practiced in relation to the mental hospital or not, has gained in the resurgence. No longer is there an unbalanced emphasis on organ-pathology as the basis of mental disorder. Not often is there an exclusive assertion of emotional breakdown as a consequence of intrinsic personality conflicts. Much more emphatically and frequently is there a concern for the individual as a psychosocial entity, using his physical, psychological, and social strengths to the best of his capacity.

This concern, as an over-all of psychiatric attitude, has some implications which require more detailed attention. One very important implication for our theme is that *being in a hospital represents only one phase in the*

total treatment process of disabled people. The phase called hospitalization is necessary and important only insofar as it allows the maximum of concentrated study and application of current knowledge. Nowadays study and knowledge imply very special facilities for investigation and treatment under controlled conditions. But the achieving of technological advantage and/or conditions of better control must not be at the expense of the overall treatment situation—the fore-thinking and after-planning are other phases of the treatment process to be integrated with the hospitalization itself. The ill patient reveals himself in the community and will eventually show the effects of treatment to the community. Any dislocation between hospital and community at the place where fore-care gives way to hospitalization or where hospitalization moves on to aftercare is fraught with danger, disadvantage, and ill consequences to the patient.

It is probable that there would be little argument favoring the dislocation of hospital from the community; almost all, if not all psychiatrists would assert the principle of continuity of treatment and treatment planning. The assertions would carry, no doubt, many reservations as to what any particular treatment plan should be, what modifications were necessary as the illness manifestations unfolded over a time span, and particularly what balance of physical, psychological, and social measures should be held. Further, most psychiatrists would state that they attend to such a principle in practice. In actual fact, it is extraordinarily difficult for all of us not to prejudice the patient's notion of psychiatric hospitalization when trying to help him before hospital treatment comes up for consideration. Secondly it is difficult, in working with patients in the hospital doing everything possible to minimize a residual disability, not to derogate or otherwise prejudice the need for aftercare. These slants of derogation or prejudice feed back to the community with further effects on the principle of continuity of treatment.

The problem of seeing treatment processes as wholes despite the different phases involved is made more difficult for psychiatry because of the complicated and artificial differentiation of hospitals within the hospital system. The psychiatric division of a general hospital, the university psychiatric clinic, the private hospital, and the public mental hospital, all have different relationships to the community, with different opportunities in different areas of accepted responsibility. It seems worthwhile to review these briefly in respect to aftercare.

The psychiatric division of a general hospital takes on the meaning of the general hospital in the community. It is linked to the community through the family doctor, the board of governors, and the visitors with their voluntary associations. The notion of mental disorder is euphemized to that of "emotional disturbance." Treatment is direct, speedy, and frequently effective—for example, where a fulminant emotional upset is triggered in a neurotic subject. After discharge, continued treatment tends to be represented by office psychotherapy, social casework, and more rarely by therapeutic or social groups. Day-hospital facilities are becoming increasingly available as a transitional service, with the addition of activity and counseling programs. Social replanning and readjustments tend to be left to the traditional social agencies in the community; in the areas of residual disability, the main concerns are the afterproblems of the chronic psychosomatic illness and the motivational problems arising in the course of physical rehabilitation. The general picture is that of moving out into the community in directions concordant with but limited by general hospital philosophy.

The university psychiatric clinic is related to the public through its representation of scientific endeavor and educational purpose as well as through service. Within wide limits any reasonable plan of psychiatric inquiry in whatever field will attract support. Exploratory projects have been initiated over wide new areas, some in the fields of residual disability and aftercare. But research explorations are not permanent services and at some stage the responsibility of the community to take over an aftercare service may become an issue.

The private hospitals tend to be forgotten when aftercare services are under review. Because of the assumption of monetary or class standing, aftercare in terms of private patients sounds incongruous. Nevertheless, many private hospitals have contributed greatly in particular areas—for example, the follow-through on the hospital phase of treatment for chronic alcoholism or drug addiction. Here particular linkages with community leaders are often direct and supported by private funds.

The public mental hospital, in its rapid emergence from the lonely state of relative public neglect, found itself strengthened in its original purpose of caring for people until a remission or respite of illness came about. The remission possibility had been hastened by active, usually physical, therapy with supportive psychotherapy. But the effect of such therapy had not been exploited by further psychological or social efforts. Readmissions or failed discharges tended to offset the "return to community" gain. The community, implicated in the aftercare of current cases, became critically aware of a stagnant chronic mental hospital population. The climate of criticism evoked new notions of liberal care with an emphasis on freedom, open living, living in some kind of community relationship, if possible living in the community. The mental hospitals have heretofore found themselves responsible for three general kinds of services subsequent to the active treatment hospital phase: (a) the effective family and vocational adjustment of well-remitted patients; (b) sheltered living arrangements, embracing family contacts and work potential from which a later "in the community" adjustment might be effected; and (c) more or less permanent sheltered living arrangements where at least a moiety of family contact and work realization is accomplished.

A short review of the different kinds of psychiatric institutions in the mental health field is sufficient to point up differing notions about responsibility for residual disability in the context of continuity of psychiatric treatment from the beginning of breakdown to the endpoint of best (however partial) remission. Yet, however

different in outlook, all are involved in the problems of residual disability, carrying their various supporting publics with them. If, in the general hospital system, it is stated that in this day and age residual disability in mental disorder need not arise, then the associated laity will fault the mental hospital system. If in the mental hospital system it is stated that the university clinics are experimenting and exploring, but are not helping in a practical fashion, then the associated laity will lodge grievances—and so on. The summation of all such professional and lay attitudes make a climate in which the principle of continuity of treatment meets unnecessary difficulties and hazards. Nowadays, however, the great attitudinal problems associated with facts of residual disability are being resolved. It is agreed that even with the best exhibition of medical and psychiatric shells a full remission will, in many instances, not be achieved. But equally it is agreed that the situation of residual disability is not only one of deficits, but also always one of realizable assets. In short, the objectives common to all psychiatrists are to mobilize assets for community living and to minimize deficits.

This is essentially a social concept which envisages the psychiatrist undertaking social action. But where a patient is concerned, social action is not so much a generality as a particularity. Developments and movements therefore start in a local scene: the starting point represents a local opportunity for experimentation.

One of the most significant features of the exciting developments in social psychiatry is the seizing of local opportunity by psychiatrists who have exercised both special training and general human qualities. Repeatedly in the literature, the quality of opportunism reveals itself either explicitly or by implication. The particular worker has had an idea which he brings to the scene of his everyday work; there he relates it to what is happening about him, and suddenly timing and relationships are appropriate for a testing. The timing and appraisal of relationships represent the tactical aspect of work in a social laboratory; without an appropriate appreciation of the patient's psychological and social needs, or the attitudes, hopes, and frustrations of other people involved, or of opinion-movements in the community, the psychiatrist would not have gained his entry. By being in the community, being part of the community, and sensing need, he has been allowed to test the application of a good idea with the responsibility of proving or disproving beneficent effect.

It may well be that efforts of this sort have been facilitated by public education endeavors in the field of mental health. The likelihood is the greater the more the instruction medium—newspaper, radio, TV, etc.—has addressed itself to local groups on specific issues, presented in terms of "for" and "against." But a common-sense analysis seems to show that such presentations mobilize support or opposition to an ongoing venture, rather than initiate a new experimental procedure. Similarly, attitude-research or public-opinion research does not, at the moment, seem to offer tools which may be used to greater advantage than may be the perceptions of a social psychiatrist working in a specific setting to prepare the way for the acceptance of a practical plan of help. At any rate the total of social experimentations, starting from single points in the community and relevant to aftercare and rehabilitation, is beginning to assume large proportions with good hope of still further increase.

The psychiatrist and psychiatric professional worker in the community, when he addresses himself to the problem of residual disability and aftercare, will have an increasing awareness of the many public groups and bodies which make up the whole of the society with which he is working. As he seeks to exploit his timing for planned developments, he will find that each group will offer its own problems conceived in terms of balance of help and opposition. To see these problems sensitively and to work with them, the psychiatrist will require some insight into his own social class positions; they will be multiple and various according to how he is perceived by others and how he perceives others. A ranging flexibility will be required of him in successive patterns of relationship as he takes up and breaks off the varying contacts symbolizing patient, family, friend matrix, acquaintanceship contacts, vocational milieu, community and controlling agencies.

Some considerable emphasis has been given here to the quality of ranging flexibility desirable in any psychiatrist or psychiatric professional worker who is undertaking aftercare and rehabilitation problems in the community with community cooperation. The artificial and complicated separation of the psychiatric hospital systems, already referred to, adds to the desirability and makes it a necessity. If a functional unification of aftercare services is to be achieved within an identified community, there would appear to be a need for cross-appointments between the various hospital systems. No doubt the future holds the possibility of some unification of psychiatric hospital services on a regional basis. Until that time, although leading up to it, a liberal diversification of psychiatric appointment would strengthen coordination of effort.

Coordination of effort in the aftercare field cannot long remain unstrengthened. As more and more experimental ventures prove successful, and as localized tactical gains add up to advance on a broad front, the need to resolve overlap and consolidate organization will the more involve community authority. To build up that authority now, at a level below governmental political authority and more nearly related to community management, will require, not only emergent leadership on the part of psychiatry, but also submergent leadership. Submergent leadership implies a responsibility to look now, in the present, at the ways in which the vested authorities which we each hold are inappropriate. The purpose of such a study would be to determine how we might properly relinquish outmoded structured positions and plan realignments of position and function suitable to the responsibilities of the next generation of psychiatrists. If psychiatry is well advanced into its phase of social concern, then its own social hierarchy and its own social institutions and functions must come under review.

Controlling Bodies

Discussion Leaders:

JOHN J. BLASKO, M.D., and STEWART T. GINSBERG, M.D.

Controlling Bodies incorporate government agencies, legislative bodies, proprietors of voluntary and private hospitals, trustees, budget directors, financing groups, the courts, and the police.

ALTHOUGH IT WAS RECOGNIZED that aftercare, medically speaking, is a continuum of total treatment, aftercare programs might better be put on a legislative program basis in order to obtain the necessary budget support. For purposes of this discussion, aftercare was defined as a program designed to maintain or strengthen the improvement attained by a patient during his hospital treatment, and to increase his likelihood of making a good adjustment to community living. Aftercare, in this sense, was distinguished from such related programs as nursing-home and boarding-home placements, which are in reality extensions of hospital facilities, with the patient still a part of the hospital census. On the other hand, certain family-care programs, in which patient and family are matched in order to strengthen or assist the patient's community adjustment, may be considered as aftercare.

An aftercare program should be carefully structured and legislatively endorsed. Legislative bodies, as well as the executive branch of the government, would be more receptive to such programs if some good method of controlling costs could be evolved.

Some states, Michigan among them, have attempted to define a framework for their aftercare program, and to seek budget support directly from the legislature. This seems more realistic than attempting to operate aftercare services to the detriment of inservice facilities. Both internal staff support and external group support of the concept of aftercare are easier to enlist if the program is a legislative one.

Is aftercare primarily a hospital or a community responsibility? Opinions seem to be equally divided, but with a suggestion that the hospital staff or the staff at the state office should take the lead in initiating such programs. In some states, because of the commitment laws, patients on aftercare status are still the legal responsibility of the hospital, and therefore the hospital must assume responsibility for such a program. Without some coordinating body, there is a risk of "fragmentation" of the patient—one comment being that the patient "must be a pretty well-integrated person to be a good patient!" The more community agencies engaged in providing aftercare services, the greater their risk becomes.

Is every patient who leaves the hospital automatically an aftercare problem? On the contrary, aftercare should be on a selective, individualized basis, according to the needs of the discharged patient. Some should be referred to specialized facilities, such as those for alcoholics, for the aged; to child guidance clinics, family service agencies, marriage counseling clinics, even to ministers or family doctors. Private psychiatry, too, has considerable concern with aftercare, and in Oregon, the law recognizes this concern. Aftercare facilities, carefully planned, will further the potential practice of a private psychiatrist, and will, in many instances, draw such a private practitioner to a community.

COOPERATING AGENCIES

A limiting factor in the development of effective aftercare programs is the fact that the community services are already overworked and understaffed, and it is therefore difficult for them to undertake the additional workload of providing aftercare services for discharged state mental hospital patients. In spite of this, a good working relationship with such services has been established in many areas. Among "helping" agencies utilized are social workers in the community; ministerial groups; Alcoholics Anonymous; employment agencies, especially state employment offices; general practitioners; visiting and public health nurses; county welfare departments; employers; the police; judges and other county officials; volunteers working with patients in nursing homes and foster homes; volunteers working in the community with ex-patients; and, of course, the patients' own families. Mental health associations have been instrumental in instituting or supporting various aftercare and rehabilitation services.

State mental health controlling bodies vary in the amount of aid given to patients on aftercare status; services range from no follow-up, to the furnishing of

psychiatric care and medications; some states provide medications to ex-patients; others give a fixed financial amount for care and/or medications; still others give an unlimited subsidy.

Controlling bodies more concerned with aftercare than with inpatient services include state, Federal, and private employment agencies; personnel officers of industrial plants and other organizations; Goodwill Industries; welfare agencies; the state office of vocational rehabilitation; and special aftercare clinics.

"Attitudes" toward the ex-patient are probably the most negative factor in aftercare programs—negative attitudes on the part of the hospital staff, of the patient's family, of vocational rehabilitation personnel, and of the general public.

A need for greater assistance from vocational rehabilitation agencies was expressed. Their members seem to have a tendency to avoid working with ex-mental patients, but when the counselors have been oriented and have been helped to achieve successful results, they will exhibit considerable interest in continuing to work with such patients. Perhaps counselors who are to work with ex-mental patients should be given special training.

Preparation of the patient—himself a "controlling factor" in aftercare—was stressed, as well as preparation of the family and of the helping and controlling agencies enumerated. Some hospitals perhaps place too much stress on getting the patient out of the hospital at all costs, and thus fail to give him proper preparation and to seek a suitable placement if this is needed.

Professional Bodies

Discussion Leaders:
HARRISON S. EVANS, M.D.
J. B. BOUNDS, M.D.
DAVID F. VAIL, M.D.

Professional Bodies include referring and consulting physicians and agencies, as well as those to whom discharged patients are referred, and other professionals who provide services to mental patients.

INTRODUCTION BY DAVID J. VAIL, M.D.

THE PROCEDURES AND RELATIONSHIPS which bring about certain results in an aftercare program will sooner or later bring about similar results in a preadmission program, and vice versa. The community physician who has been properly educated about the needs of the returning patient will tend to be that much more skillful in making referrals to the hospital. The doctor, whose preliminary inquiry about voluntary admission is well handled will tend to be a better friend of the hospital and a better resource for posthospital referral. The aftercare process, the *relationship* that becomes the soil of service to the patient, begins at this earliest point. I have emphasized the positive, and need hardly comment on the negative, the bad experiences, except to say that ill-feeling reverberates and that trouble begets more trouble.

Local community factors and the administrative-legal framework in which the hospital operates are bound to influence preadmission and aftercare services very markedly. The hospital serving an area which is sparsely populated, poor, and empty of professional people, will have a much different set of problems from those of the institution located near a city. Commitment laws are important. The hospital which accepts patients only on court commitment will have relationships with community professional people, different from those of the hospital which is geared to a voluntary admissions service. One of the main advantages of the voluntary procedure is that it provides a sound basis for community relationship. The medical-certification type of commitment, especially where the hospital is permitted a choice of accepting the patient, offers a unique opportunity to educate local physicians. The aftercare program of a hospital which operates its own outpatient department will involve an entirely different set of relations from those of the hospital which must always refer to some other agency.

The real issue, I suppose, is that of responsibility. Before a patient enters the hospital, responsibility is diffused. From the time he comes in, or more accurately from the time the hospital makes its own commitment in helping to arrange his admission, responsibility is concentrated in the hospital. Regardless of what may happen to him after he leaves and irrespective of laws which may fix legal responsibility elsewhere, the hospital still bears the moral obligation, and this is ultimately the real responsibility.

In the realm of law and administrative policy on aftercare, one encounters a wide variety of patterns. First of all, one must single out the agency which bears the major portion of the legal and administrative responsibility for aftercare. A partial list would be as follows:

1. The hospital itself, through:
   (a) Its own outpatient clinic
   (b) An outpatient clinic staffed and administered by the hospital, but located at some distance, for example in a city which is the major population center served by the hospital
   (c) Traveling clinics
2. The state mental health service through outpatient clinics where patients are referred for aftercare.
3. The state mental hospital authority through indirect supervision of outpatient clinics or mental health centers financed by state and local funds.
4. The state public health department, through clinics or some form of aftercare services quite distinct from the administrative channels of the mental hospital.
5. The county welfare departments.
6. The county probate courts.
7. The state office of vocational rehabilitation.
8. The medical profession.

I have listed them not in order of importance, but in order of administrative logic and the statistical likelihood (only a guess, really) that administrative or legal responsibility will be so fixed. Thus I would imagine that the most frequent pattern is where the hospital provides its own services directly. It is possible to devise a grid and to chart these patterns rather exactly, thus making it very easy to pinpoint one's own hospital or state in such a scheme. In Minnesota, for example, the county welfare departments, since 1953, have had by statutory law the responsibility of providing aftercare services. At the same time, some of the hospitals have what amounts to a small outpatient service for their own dischargees. We have had clinics operated directly by the state, one of them exclusively for aftercare. These have been superceded by mental health centers administered locally with state support. The 1957 law which gave rise to the latter development also designated rehabilitation of formerly hospitalized patients as one of five major objectives of community mental health services. And so it goes—no two states seem to be alike.

THE UNANSWERABLE QUESTION

The obvious question is, which system is best? The next question is, who could possibly answer such a question? At the heart of it is the eternal constitutional problem of depth vs. breadth; efficiency, uniformity, and direct control vs. diffusion, diversity, and local responsibility. Many factors such as geography, state economics, and adequacy of staff enter into the equation. A traveling clinic works fairly well in New Hampshire, a small state served by only one hospital. Elsewhere this facility appears to be out of fashion, if not in actual disfavor. Medically it is unquestionably better to have the same treatment team follow the patient after he leaves the hospital. This works well in Great Britain, where geography, population density, uniform laws, and (dirty word) "socialized medicine" combine to make such a system possible. But this is not so easily accomplished where the hospital serves an area comprising a score of counties and several thousand square miles, and has about enough professional staff to do the inpatient work, and that badly. It is painful for the physician to turn over the care of his patient to someone else but, more often than not, it is a practical necessity.

CATEGORIZING DISCHARGEES

One thing to bear in mind is that not all patients are of the same type. I have thought of four basic categories of patients leaving the hospital:

1. Patients whose illness is recent, who are articulate, who are, in other words, good psychotherapy cases. Such patients are sometimes welcome at outpatient clinics of mental health centers.
2. Long-term patients reactivated after many years of custody. These people need help in basics: finding and keeping a job, obtaining suitable lodging, becoming accepted in the community, and other case-work concerns. Here the county welfare workers have a particularly important role to play. Let me add parenthetically that, in the vast majority of U. S. communities, the county welfare department is the only organized social agency.
3. Patients whose needs are predominantly medical rather than psychiatric and who may require not only nursing care, but specific medical attention. The general practitioner is invaluable for such a person in particular. (This is not to underestimate the family doctor's importance throughout.)
4. The patient on tranquilizers whose medication schedule and dosages have been worked out, sometimes after months of careful and painstaking work. Nothing is more heartbreaking than to have such a patient break down and return because a local physician became alarmed at so much chlorpromazine, or otherwise botched up the medication regimen. If a hospital is to operate its own outpatient department, this would be the first category of patients to include.

I would like to mention one important finding which emerged from the recently terminated Minnesota Follow-up Study. Unfortunately we lack sufficient statistical proof. It does seem fairly clear, however, that with given staff resources to be applied exclusively to providing aftercare, the results are better when this emphasis is at the community rather than at the hospital level. We also found that the main value of the community staff team was not in the direct casework service which it was able to provide, but in the consultation, education, and coordination which it did in relation to other already-existing and well-established social and professional agencies, and to the local physicians.

Clearly there is no set way. I personally regard the aftercare problem as one of the toughest we have. I also think that it subtends the entire field of public mental health administration. I am reminded of a dictum of Sir William Osler's which I might paraphrase: "He who understands aftercare understands all hospital psychiatry."

GROUP DISCUSSION

ALL THREE DISCUSSION GROUPS adopted independently the same principle, which may be expressed thus: aftercare, like hospitalization, is only a phase in the whole therapeutic process, and cannot be properly separated from the patient's hospital experience, or any other part of his career as a patient. For the sake of focusing their discussion, however, all groups agreed that they would limit themselves to those services or contacts which occur directly in connection with the patient's departure from the hospital, and his subsequent integration into the community.

Here a vigorous complaint was made by one group: although there appear to be good *prehospital* lines of communication between the hospital and the community professional groups because of the community's desire to get the patient admitted, the *posthospital* ties are not so strong. The referring agencies do not want the patient back. Where, however, there are good posthospital relationships with the participating agencies, the re-admission rate is greatly decreased.

It is difficult to generalize broadly about "the needs of the returning patient." Patients vary widely in their proportionate needs for medical care, welfare assistance, vocational guidance, and so on. They come from public and private hospitals; they belong to well-to-do and not-so-well-to-do families. But the basic resources must exist, and the hospital itself be willing to take the responsibility for prescribing the proper balance of service. Aftercare can become just as routine and "institutional" as can the inhospital experience, and this will result in dependence on the hospital's outpatient department, or on some other agency or professional person.

FLIMSY ORGANIZATION

There is little agreement as to the proper mechanisms for providing aftercare. At present, the entire structure of such programs is hazy and flimsy, and it is debatable whether many mental hospitals have even what can properly be called an organized aftercare program. Where there is one, it tends to be centered in the hospital itself, and next most frequently, at public clinics operated by one state agency or another.

The really critical issue is that of continuity. Where real continuity exists—i.e., communication between hospital and community—the formal administrative structure of the program is of secondary importance. However elaborate the program, it will break down if this continuity or communication is inadequate.

The idea reached in Great Britain, where the same professional staff meet with the patient in the community, follow him in the hospital, and provide him with care and supervision after his discharge, has not been achieved in this country, although such programs as the Clarinda Plan and the program at the Montefiore Hospital, Bronx, New York, are brave efforts to accomplish this objective.

Other attempts at continuity, somewhat less specific, are taking place in various states. Ohio has found that its chain of small receiving hospitals are able to enlist good public participation. The programs spill over into contacts with community groups other than those which, by strict definition, can be considered professional. (This points up the fact that, especially for purposes of aftercare, it is no more realistic to separate the professional from the nonprofessional community than it is to distinguish between the official and unofficial community.) Community assistance in Ohio, therefore, includes adult education programs; state funds for vocational training; invitations for hospital patients to attend clubs, art galleries, concerts, shows, and other community events. Union officials visit the hospitals to talk with patients about jobs after discharge. The local library extends its services to the hospital. Volunteers teach the patients to shop, budget, cook, and make clothes. These activities permit the cultural growth of the patient, reduce his insecurity, and finally lead to his acceptance and respect when he becomes an ex-patient.

GEOGRAPHICAL VARIATIONS

In rural areas of Minnesota there are similar programs, with a little more emphasis on agriculture because of the nature of the surrounding areas. Oklahoma's own hospital social workers do their own follow-up, with the aid of the welfare department. Throughout the patients' hospital stay, everything is done to encourage the public to come in and in turn to invite inpatients out for visits and activities.

In some hospitals in Massachusetts, private physicians are invited in to follow their patients, and are often induced to work with community agencies, both before and after admission and discharge. The social workers do much to help coordinate the clinical program, and carry on considerable casework with families. As much free service as possible is offered to the community, including work with school counselors, with universities and with the courts. An increasing number of states are working hard to involve private physicians who can, in fact, offer possibly the most valuable continuing link of all.

Perhaps a basic problem is the difficulty in relinquishing the patient, but at the same time, in maintaining moral responsibility for him. To accomplish this apparently paradoxical feat means that the hospital must forego direct service after discharge, in favor of developing other sources by means of consultation, cross appointments, and, of course, continuing communications. This broadens the boundaries of the hospital. It requires courage, resistance to confusion, and an ability to tolerate the itch to protect!

ENCOURAGING TRENDS

In summarizing aftercare experiences with professional bodies, the discussants singled out several encouraging trends.

1. The community attitude toward the discharged patient is improving at least as rapidly as had been hoped. Specifically, the attitudes of neighbors to family-care homes and those of prospective employers are becoming increasingly tolerant. However, the mobilization of efficient aftercare still has

to be initiated and supervised by the hospital, if it is to be done properly.

2. Public health and visiting nurses assisting with aftercare programs are enthusiastic about hospital training programs set up by the mental hospital to orient them, and in exchange, they keep the hospital informed about the progress of discharged patients by making frequent home visits. Cooperation between hospitals and these two nursing groups greatly improves aftercare.

3. There has been considerable progress in Kentucky and North Carolina in transferring senile patients from the state hospitals into nursing homes. The chief obstacles are financial, budgetary problems. In North Carolina, much interdepartmental red tape has been side-tracked because the Departments of Mental Hygiene and Welfare are under the same administrative head. A department of welfare is felt to be traditionally too concerned with costs to be able to offer much cooperation in stemming the flood of geriatric patients in most mental hospitals.

AREAS FOR IMPROVEMENT

Concluding their summary on this subject, the groups agreed that, while the above trends are encouraging, there is plenty of room for improvement:

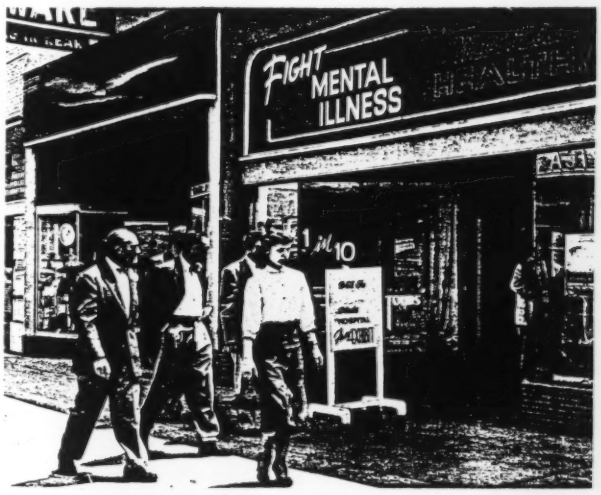
1. There are still large areas wherein we could make more use of social service in doing predischarge casework and aftercare follow-up. Relatively little use is made of the Council of Social Agencies as an aftercare extension of a hospital's own social service.

2. We are frequently requested to make decisions as to a patient's ability to carry out various complicated jobs with machinery to evaluate his aptitude to handle an automobile, run a steam roller, or sell insurance. As a group we should restrict our tendency to overextend our qualifications in specialized fields for the apparent advantage of our patients. In many cases, we are ignorant of the demands that specialized jobs would make and should frankly admit it.

3. It is all very well to be smugly critical of the fact that the general public and the nonpsychiatric physicians have no awareness of the available community psychiatric resources that might help to avoid unnecessary hospitalization. There is also an unflattering mirror image: we find that when our immediate therapy is completed and discharge of the patient imminent, we are just as guilty of ignorance and indifference toward what the community could offer in the way of aftercare for the patient through such agencies as the Salvation Army, Catholic and Jewish Family Agencies, Family Service, Council of Social Service Agencies, and others. •

Community Service Bodies

Discussion Leaders:
ROBERT C. HUNT, M.D., and MRS. ANNA T. SCRUGGS



Community Service Bodies embrace such resources as mental health associations, service organizations, and civic organizations.

TOO MANY COMMUNITY AGENCIES still stigmatize the exmental patient, and tend to reject him or to deny him the benefits he might otherwise receive. A partial cause is the feeling that the state is entirely responsible for the care of the mentally ill person, even after he has returned to the community. Thus the local community service agencies do not accept the fact that his aftercare is a part of their function.

On the other hand, there is a proliferation of service agencies, which, as in a comparable situation with professional agencies, results in ex-patients being shunted from one to another, and rejected all along the line, until many of them "fall between the cracks" and never get any support at all. This is attributable in part to a lack of understanding on the part of hospital staff as to what community resources are available, and how they can properly be used. This lack of understanding also contributes to too great a lapse of time between the actual discharge and referral, and the time when the agency begins to act. When the necessary action is finally taken, it is often too late.

On the other hand, when there is proper communication between the hospital and the community, the

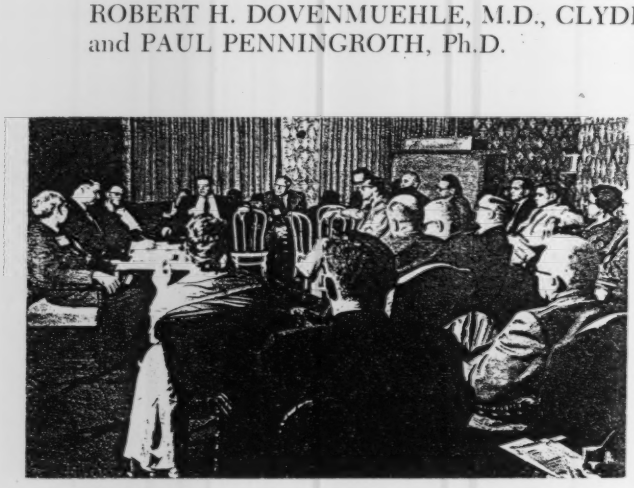
community services make great contributions to the support of the discharged mental patient. A good example of a useful community service is the placement of a patient in suitable employment, or assistance in maintaining him financially until he becomes able to support himself again.

Community organizations are very willing to help when they understand what the problem is and what is expected of them. A central council of key community agencies can be effective in some areas, either in serving the returning patients directly or in making referrals to the proper agency. This device leads to the development of better agency acceptance of the patient, and thus to his receiving quicker service.

Needless to say, a good treatment program in the hospital results in greater community service cooperation, and leads to a better acceptance of the patient when he is ready to return home.

The Scientific Community

Discussion Leaders:
ROBERT H. DOVENMUEHLE, M.D., CLYDE MARSHALL, M.D., and PAUL PENNINGROTH, Ph.D.



The Scientific Community covers the A.P.A., the A.M.A., and other medical associations, county medical societies, research and educational groups, and publishers of professional or educational journals.

THE QUESTION OF RESPONSIBILITY for aftercare programs exercised the attention of all three groups concerned with the scientific community. If the responsibility is based in the state hospital, the patient may feel as if he is "paroled" from jail, with return to the hospital hanging over his head like a sword. If the district medical society is to urge the general practitioner to take responsibility, it will be found that some do not wish to treat ex-mental patients and that others may not have the necessary skills.

One group stated categorically that aftercare is a community responsibility and that both the staff and the operation of aftercare facilities should be community- rather than hospital-oriented. This group stated that the function of an aftercare facility is to "release patients, letting them become something other than "patients." Staffing then should consist of professional people who know community resources and are trained to work with patients and families in the community. The social worker is the obvious choice. Psychiatrists might be involved in special instances, but the mental hospital staff philosophy should be, "We can't take aftercare responsibility."

Another group emphasized that the role of the large mental hospital is changing to one common to any other referral-hospital. This implies that the function of the "scientific community" is to stimulate professional groups outside of the hospital. Mention of the mental hygiene clinic as a resource available to discharged patients brought out the comment that such clinics are too much involved in long-term psychotherapy. This group repeated the oft-heard statement that the mental hospital should consider aftercare as its responsibility during the actual admission planning, and recommended halfway houses, foster homes, and convalescent home-care, supervised by hospital personnel; hospital contact with the patient should be maintained.

The third group concentrated its efforts on the difficulties connected with aftercare planning, noting that there are two extremes of philosophy: the one, that aftercare services are unrelated to hospital treatment or prehospital activities, and the other, that aftercare is part of the patient's continuing career as a patient.

There is no agreement on the stage of recuperation at which the patient should exchange hospital care for aftercare, nor upon the kind of patient who can best profit from early discharge with immediate aftercare. The location of the hospital, its size, and the kinds of service it can offer will determine its discharge policies. Unless the hospital can discharge the patient with the assurance that aftercare is available, early discharge will simply transfer the hospital problems into the community.

LOST IN THE SHUFFLE

The lack of organized community services is the worst difficulty, especially the unresolved question of responsibility. Community agencies, too often isolated from one another, will cause the patient to be either lost entirely, or shunted from one agency to another.

The difficulty of obtaining suitable employment for discharged patients is one of the most serious problems in planning for discharge, and this is aggravated by the fact that many hospitals themselves will not hire an ex-

patients. Yet no great problems nor unsatisfactory experiences have been reported by those institutions which have employed such people. The hospital which expects the community to hire ex-patients should be willing to set an example. Archaic rules and regulations, such as the automatic cancellation of drivers' licenses, and revoking of professional licenses when a person becomes mentally ill, adversely affect employment. Here, it was thought, a national professional body should look into this and related questions, and suggest ways to overcome such practices and limitations.

The function of the "scientific community" in relation to aftercare services should be to guide hospitals in establishing them and to make more exact statements of policy and philosophy. The university, a very important element in the scientific community, could well take the initiative. National professional organizations should hold open forums to define the problems. Problem-definition may be as important as problem-solving. National bodies could also assist by providing liaison, both vertically and horizontally, between the A.P.A., the A.M.A., and other medical bodies, as well as with such other professional groups as the American Bar Association.

Local medical groups, unfortunately, show the least interest in helping to provide aftercare services. Solutions will be found primarily through direct and indirect educational practices. Among these might be: the appointment of local medical personnel as mental hospital consultants; increased participation by hospital staff members in local medical activities; invitations to medical groups to hold meetings at the mental hospital; treatment by private physicians of their patients who are in a mental hospital; and friendly personal relations between hospital profesional staff and community medical group. It cannot be denied, however, that some hospital regulations and administrative practices interfere with some of the educational devices described.

A very positive factor in assisting in the development of aftercare services, however is the technical assistance projects made possible by the N.I.M.H. The special value of these projects is that they are geared specifically to some of the local difficulties.

One interesting example of first-rate coordination and therefore of good aftercare service is a demonstra- of aftercare services, however, is the technical assistance tion project in a city in Florida in which medical, social, and public health agencies, county medical societies, and the ministerial group collectively organized aftercare services. These agencies are coordinated through a professional committee which meets biweekly. The committee secures information about patients about to be discharged, assembles all local information about them, and then plans which agencies should be utilized for the patients' aftercare. •

The Patient-Community

Discussion Leaders:
NELL T. BALKMAN, R.N., and T. J. BOAG, M.D.

The Patient-Community refers specifically to the other patients with whom a patient is associated either in or out of the hospital.

BOTH GROUPS WORKING in this topic expressed concern as to the continuing label of "ex-patient," which might imply continuing stigma attached to the person who has once been a patient in a mental hospital. The term, while being descriptively correct, has emotional connotations which present considerable problems. Another comment was that some patients do not have contact with other patients once they leave the hospital, even if they receive some form of aftercare. And finally, the question was raised: Do clubs for ex-patients serve to isolate the former patient from the rest of the community, and to cause over-dependency, thus slowing down or stopping entirely the total readjustment of the individual to the general community?

Again, the problems were resolved by attempting to orient discussion toward the specific needs of *individual* patients. Many people with considerable residual disability never progress beyond a certain point, and for such people, there are only two alternatives, unless some intermediary organization can help: to remain in the hospital, or be rejected once again by the community. In the latter situation, some of these people will simply sit around in their rooms with nothing to do, and many will eventually relapse. For such patients, a therapeutic social club can be quite useful, although the presence of too many passive-dependent members may have an adverse effect upon the attendance of others who have better prognoses.

Generally speaking, more community planning is needed; the more facilities and alternatives there are available, the more effective the maximum adjustment

of individuals to the top of their ability can be. Numerous local projects exist, one of the key organizations being the so-called halfway house. This term needs further definition; it might best be considered as part of a continuum of facilities, from the hospital community at one extreme, to the community at large at the other, with "quarter-way," "halfway," and "three-quarter-way houses" in between. Closest to the hospital would be a house on or near its grounds, staffed and administered mainly by hospital personnel. As these facilities move further away from the hospital, both geographically and psychologically, they will become more like hostels, and will be run by community organizations.

GOALS DIFFER

Some clarification is desirable of the differences between day and night hospitals, halfway houses, and "therapeutic social clubs." The hospital, full or part-time, is primarily a place where medical treatment is the main aim, whereas the halfway house and its relatives have as their prime objective the adjustment of former patients to life outside the hospital. The further these facilities are from the hospital, the less responsibility the psychiatrist takes, and the more other people from the community become involved.

In Idaho, two chapters of the New Horizons club have found that membership helps give ex-patients self-confidence. They like to help one another, and while members of the hospital staff frequently attend meetings, the patients are not dependent. Far from staying away from the community, they are gradually becoming involved in community activities of all sorts. Their attitude is "I am an ex-mental patient. I am well now. I am not ashamed of my former illness." Membership in these clubs is voluntary, and members, once joined, seldom drop out.

In other states, similar programs are found to be successful. Circle F in Minnesota[1] is a volunteer organization, sponsored by the State Department of Public Welfare, the State Division of Vocational Rehabilitation, and the Greater Minneapolis Council of Church Women. This demonstration social rehabilitation project is directed by a trained social worker. In Michigan, state hospital patients go to social events at the local "Y" where they associate with members of the general public as well as with ex-patients and volunteers.

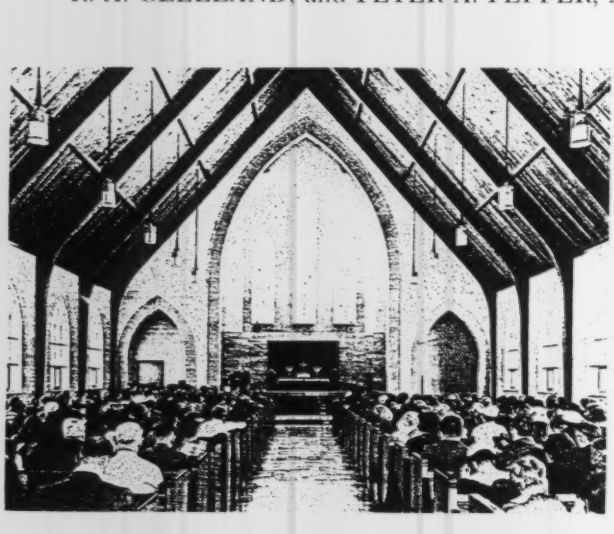
The question of employing former patients in hospitals as either staff members or volunteers is always a hot discussion point. Are such patients likely to want to spend the rest of their lives in this environment which has proved comfortable and easy, and thus limit their possibility of further readjustment to the community in general? It is admittedly true that visits to hospitals from former patients do stimulate others to want to leave, even though previously they had regarded discharge with some apprehension. Such "visiting" patients, however, should be carefully selected.

Among practical problems raised was the difficulty some ex-patients experience in obtaining prescribed medication. Occasionally it will be found that ex-patients meeting in groups will borrow or loan drugs to one another, irrespective of dosage or kind of medication. This points up the importance of their being given complete information about their medication, why they are getting it, what it is, and so forth.

[1]*Walz, Thomas H.: The Circle F Club: A Community Social Rehabilitation Project, Ment. Hosp. 11:7:36-37, Sept. 1960.*

The Patient's Social Community

Discussion Leaders:
R. A. CLELLAND, and PETER A. PEFFER, M.D.



The Patient's Social Community takes in his family, his neighbors, his employer or school, his church, and other groups with whom he normally associates.

IT IS WHEN THE PATIENT has completed his hospitalization and is ready for aftercare that the various elements in his social community assume their greatest importance. Once again he is among his associates and their prevailing attitudes affect him intimately. If these are such that he is excluded from jobs, from normal social situations, sometimes even from taking his natural role in the family, he is a prime candidate for rehospitalization.

In discussing the problems of securing aftercare and continued rehabilitation services for the discharged mental patient, one group decided that they are much the same as those which stand in the way of treatment. Uninformed public attitudes and lack of understanding of

modern treatment concepts cause communities to refuse responsibility for returned patients. This is further complicated by shortages of personnel. Hospitals and clinics all over the country are crying for trained psychiatric workers; funds are available but positions are filled only by robbing other centers. Again the primary responsibility was laid at the door of the hospital. The success or failure of aftercare is in direct ratio to the preparation and planning prior to and during hospitalization.

A relative newcomer to the field of mental health came in for much discussion during both the treatment and aftercare sessions of this particular "community body." This is the trained public relations officer. The discussants saw his function as two-fold, with general reference to the over-all state problem, and specific reference to the relation of the hospital to its community. All agreed that a program to inform the public was basic to the establishment and securing of aftercare services.

EMPLOYMENT

One group confined itself primarily to the employment aspects of the patient's social community, and, in fact, both groups devoted most of the second day's discussion to this subject. The general feeling was that progress in this area is good. Many large organizations are now willing to employ personnel who have been mentally ill, and there are a number of excellent programs to increase industrial understanding and acceptance of the ex-patient. Some communities have formed civic committees of businessmen to help place the mentally handicapped in industry. Others have created effective committees consisting of employers, personnel heads, union representatives, and mental health professionals.

But the rehabilitation of the mental patient begins long before he is ready for employment, sometimes even before he is hospitalized. Ideally he will return to his former place of employment; thus, vocational goals should be a consideration from the very onset of illness. Increasing use is being made of rehabilitation and vocational counselors, both within the hospital setting and in the community. Some hospitals bring the rehabilitation worker from the community into the discharge planning at an early stage of the patient's hospitalization. Others have set up complete rehabilitation centers within the hospital itself. If the patient successfully adapts to a work situation within the center, he is placed in a job in the community. Some such patients remain on patient-status, working during the day and returning to the hospital at night.

Another example of job-preparation in the hospital is a member-employee program such as that of the VA. Here the patient assumes an employee status, is paid a salary, and works an 8-hour day 5 days a week in the hospital. He lives in separate quarters, eats in the employees' dining room, and is expected to fulfill the same obligations and responsibilities as regular personnel in comparable positions. Many VA hospitals set a time limit of a year on this program. Patients, when ready, are assisted in extramural job-placement by a counseling psychologist on the hospital staff. Follow-up supervision is given as long as necessary. Employers know that the hospital staff will render assistance any time problems arise.

In the community, rehabilitation agencies have discovered that there is less cost involved in rehabilitating a mental patient than there is with one who suffers from a physical disability. Some agencies offer not only counseling and job-placement service, but also on-the-job training, schooling, economic and financial assistance, and residential homes as available resources for successful extramural adjustment.

The education of the employer and methods of obtaining job opportunities for mental patients are receiving a great deal of attention from hospital staffs and other mental health professionals. One hospital brings employers in for seminars on mental illness; another invites them to spend a day with the patients, meet and eat with them, and thus obtain a realistic image.

The increasing use of vocational counselors and the broadening of their function is paying dividends. Most mental patients need help in obtaining employment and these counselors are especially trained to provide such help. They work with state and local agencies to secure leads on job-placements, and assist patients to fill out employment questionnaires, etc. The puzzler on such forms is whether the patient should disclose the fact that he has been hospitalized in a mental institution. Disclosure often results in rejection. At one hospital, patients are advised to state, "Yes, and I am under the care of Dr. So-and-so. You may call him." With this type of reply, employers often call the physician and can receive reassurance for their fears and anxiety. Their common question is "Is he dangerous?"

The key to a successful employment program seems to be a realistic appraisal of the job capabilities of patients by the hospital staff. An ill-prepared patient can so antagonize an employer that jobs in the plant will be closed to other patients.

NEIGHBORHOOD ACCEPTANCE

Certain other aspects of aftercare were considered to be directly affected by the patient's social community. Residents in one area protested the purchase of a home in their neighborhood for use as a half-way house. Retrospective analysis revealed that there had been no planned approach by the rehabilitation staff of the hospital, and the community group had received no information about the responsibility and rehabilitation potentials of mental patients. An example was cited of good handling in a similar situation where the American Legion, the mayor, a local businessmen's group, and the immediate neighbors were contacted, and acceptance for the proposed facility was gained through adequate information and interpretation to the public.

One VA hospital maintains a foster-home cottage on the grounds to recondition patients socially prior to foster-home placement. Other hospitals have programs whereby employees accept patients into their own homes for this type of aftercare. Many neighbors to foster homes have seen patients adjust well and have requested placement of patients in their homes.

On the other hand, some neighbors, prompted by

fear, are prone to call the police on the slightest provocation. Again, education is the answer—education of the public and education of the police, since they are so often involved in the cases of mentally ill persons. The superintendent of one hospital in England gives every policeman in the town a tour through the hospital. Many U. S. hospitals hold seminars for policemen, and the Louisiana Association for Mental Health, in cooperation with N.I.M.H., has prepared a special film for them.

In attempting to delineate the factors which lead to successful aftercare, the groups discussing this subject accorded primary importance to constant and skilled follow-up services. These can be provided in many ways —half-way houses, nursing homes, outpatient clinics, foster homes, etc.—and the patient's social community should be stimulated to participate in and contribute to such facilities. However, it is vital for the hospital staff to recognize that aftercare, like any other treatment, is essentially medical and to accept the primary responsibility for it.

The General Public

Discussion Leaders:

WILFRED BLOOMBERG, M.D.
WILLIS H. BOWER, M.D.
F. E. McNAIR, M.D.

The General Public is a heterogeneous group seldom in direct contact with the hospital and influenced mainly through mass media or word-of-mouth reports from others not directly involved with mental patients.

THE VAGUE CONGLOMERATION called the "general public" is separated from the mentally ill by a barrier of ignorance, fear, and lack of interest. The ignorance and fear grow out of long-standing superstitions and lack of knowledge, and they can be corrected by education and re-education. But the apathy produced by disinterest can be counteracted only by the movement of psychiatric facilities into the community.

It is easy for the public to abdicate personal responsibility for the mental patient who is being cared for by mass action at some distance from the home front. It is much more difficult to ignore or deny the patient who is being treated in the community through a variety of facilities. The public conscience is awakened and the public pocketbook is directly affected.

Unfortunately, the general public does not understand the reason behind the professional staff's wish to move the patient out of the hospital and into the community. Such a move is interpreted as rejection of the patient or lack of interest in him. If it expects the community to accept its patients, the professional fraternity must explain to the public what it wants to do for the patient, and why a broad spectrum of services or alternative facilities is needed.

Especially, the public needs to be informed about the discharged patient with residual disability. His neighbors need to know that he is not dangerous even though he may occasionally exhibit bizarre behavior. They need also to know that the patient who is discharged from the hospital does not have to be completely well if aftercare facilities are available in the community, and if the community can be persuaded to accept him.

One of the groups discussing this problem pointed out that professional staffs often underestimate the readiness of families or communities to accept a patient and so do not seek their cooperation. Plans must be made on an individual basis in individual situations, with the professionals assuming a leadership role rather than a defensive one.

If the patient is to be identified as a full-fledged citizen and his dependency on the hospital decreased, there must be an increase in the consultative facilities and the psychiatric sophistication of the present health personnel in various localities. The patient has a right to specific facilities to determine his potential and improve his community adaptation, but he should also have some choice as to what kind of services he will use and whom he wants to provide them. Further than this he needs friendly contact out of personal interest, and this can be provided only by a public which accepts him.

The professional staffs of hospitals all over the country have an obligation to help the public accept the idea that the purpose of hospitalization is *treatment*. If the patient can no longer benefit from hospital treatment, he should be *discharged*. No person should be kept in the hospital merely because no interested relatives are available and the general public is uninformed.

SUMMARY

By JACK R. EWALT, M.D.
Professor of Psychiatry, Harvard Medical School
Superintendent, Massachusetts Mental Health Center
Director, Joint Commission on Mental Illness and Health

Support for Treatment and Aftercare Programs Depends Upon Positive Hospital Leadership

IN THE VAST AMOUNT of material produced in your deliberation, we can detect some basic findings. I have tried to bring from these some formulation of general principles and I will center my discussion on these principles.

One of the most outstanding principles is that the mental health program in general and the hospital program in particular must have clearly defined goals if they are to elicit support from the general public. The goals may vary somewhat from one place to another, but they must be those assigned by the public after discussion with the professionals.

If a community has a problem of handling schizophrenics and confused senile persons, it may not lustily support a program in psychiatric research or mental health promotion in the schools assigned by an outside agency. On the other hand, I think it may readily accept a promotion and research program as part of a general mental health program as long as it also receives a resource for the care of its schizophrenics and confused seniles.

The public has needs and our program can be expanded if we will determine what these public needs are, what the resources are, and how to make the best use of these resources. Our goals must always solve some public problem, not merely satisfy the whims of some small professional group.

We complain that our hospitals are dumping grounds for the community and sometimes they are. But someone must care for the refuse, human or otherwise. This can be handled best by showing how refuse can be salvaged, and at what level on the road to the dump. We need to show how human refuse can be salvaged into useful material. Adequate tools are needed for handling this job.

The general belief is that the hospital should extend into the community, coordinating the efforts of the various agencies and acting as a resource for care and treatment, and for the program of prevention. Most people favor continuity of service through various kinds of facilities—full hospitals, day and night hospitals, halfway houses, and aftercare programs of all types.

The second general principle is that there must be full utilization of the resources already available, of money, of manpower, of equipment, and of other factors. While no hospital is fully supplied with manpower or physical facilities, neither is any hospital fully using its available resources. I do not mean to imply that people are loafing, but I do believe they may be working ineffectively. The psychiatrist may very well be doing things which others, with less or different training, could do equally well. We all remember when intravenous injections of fluids and blood-pressure readings could be done only by a physician. Nurses now carry out these procedures well, often better than we did them as interns.

It is my belief that many tests utilizing psychiatric time may be done by a general practitioner, a nurse, a social service worker, a psychologist, or a business man. There are many tasks being performed by social workers which could undoubtedly be done by public health nurses. Some patients referred to the hospital or the outpatient department could be handled by a family-care agency or a probation officer, to name a couple of examples.

What is needed is a careful analysis of the job, and the wise use of the person with adequate skill to do it, without too much sweating over professional role or status or other impediments to a sensible operation.

The third general principle is the necessity for public support of the program. This is necessary because the services are for the public. Mental illness, however, is an unpleasant business; juvenile and adult deviations of behavior are little better; so, if left to their own devices, the public will largely ignore the problem, or when anxiety is high because of some unfortunate episode, they will discharge the anxiety by having an investigation, passing a new law, or appointing a new director or superintendent. Thus they deny the problem by having a fixed anxiety-release, and thus forget it until the next episode.

We cannot make mental illness pleasant. No amount of assuring the public that "mental illness is like any other illness" will really convince them. They receive no reassurance. They wonder what other illness we are talking about. Few people are so stupid as to think a cold, cancer, gonorrhea, and a broken leg are alike.

All illness is unpleasant and we must tell the public we are dealing with a group of seriously ill people. Some will get well, many will improve, and a few will have chronic residuals, but many can be rehabilitated, if we can get what we need to treat them. We must quit kidding ourselves and the public with catch-phrases.

Our program for educating the public may be considered under two headings: 1) educating the decision-makers, the big shots, the leaders in labor, business, religion, education, and welfare; and 2) educating the masses, the general public which is indifferent, on the whole, to our efforts, and does not attend our lectures or watch our educational programs on television.

Under both headings, two points need special emphasis: those who are to do the educational work in the community, be they psychiatrists or others, must be well-trained. Good intentions are laudable, but they cannot substitute for competence. An energetic yet incompetent person loose in the community doing his lusty bit for mental health can have an effect on your program comparable to that of a competent plumber bringing his skills to tune the pipes of an organ!

The second point is the importance of having a psychiatrist who devotes time and thought to educational programs. He should be a man with common sense, a gift for plain speaking, and enough maturity to present a truthful and clear picture which inspires confidence. He will be the best one, not only to contact the "key people" in the community, but also to teach general mental health principles in the high schools and colleges, and to encourage students to volunteer in programs in the hospitals and clinics. From the graduates of our high schools and colleges will come the next generation of leaders, and to this group particularly our education program must be directed.

The psychiatrist should also act as a consultant and a source of information to persons well-trained in public education and information. These trained "communications people" will be the ones who see that the oral or written material is very clear and specific. It is true that we have difficulty, with our existing techniques, in testing the effectiveness of our communication attempts, but it makes sense to keep trying. As we are able to offer more specific treatments for different forms of illness, or methods for the prevention of illness, the public will show an increasingly encouraging response to our efforts.

The use of the family physician, the public health nurse, the teacher, the clergyman, the foreman, the judges and the members of the legal profession as bearers of "the truth" in their daily intercourse and practice, will aid in public education.

The use of mass communication media will be helpful, but the goals must be limited to imparting facts of an impersonal nature, facts which incite action. The development of depth of personal feeling stems only from personal experience or personal identification with experience. This will come about only when people are involved in a discussion group or when working with a family member or colleague or friend who is faced with an emotional problem.

The fourth principle with which we are all in agreement is that we must solicit professional support. Psychiatry cannot work alone in the field. We must have the aid of our medical colleagues and of the other members of the helping professions. This aid will be elicited best by teaching in the professional schools. We must dwell much on those already trained, who will benefit most from consultation on the problems of their clients or patients, such consultation being conducted on a group discussion basis, with the teaching of basics as part of the approach. Participation in scientific meetings with our colleagues is another effective way of gaining the cooperation of our professional colleagues in handling the mental health problems of the community.

Some of you decry the application of general hospital standards to mental hospitals. This, I think, is shortsightedness. The long view dictates that we should reach their standards in terms of adequacy of personnel, equipment, and supplies as quickly as possible, even though the details may differ somewhat. It is true that accreditation may be withheld, but this is a fine story to take to the public and to the legislature when making your plea for better support and a better program. Unqualified approval can be a grave disaster in the middle of program development. Such approval may prove costly.

Most of us agree that the support of the legislature is gained through support by the public and professional groups. There must be presentation of a specific program with well-defined goals. We must win the confidence of the legislature by our performance on current problems and by presenting facts as honestly and comprehensively as possible. Our own attitude is also a matter of primary importance. The legislator can go and fight for our money, not only to help us, but to preserve the status of our community. His chances of re-election can also be served. If he doesn't get back in for the next session, then you will have to re-educate a new fellow. The legislators are not impressed by our bibliographical sheet but if we can solve something that is close to them, or tell them how, they will be grateful. Again, may I stress that our own attitude toward a legis-

lator is important. He knows how to sway public opinion, so we must keep the focus of the program on present and future needs. The past is dead, so let it alone.

A point which was discussed too little is service to the services, through research and educational programs to keep the profession growing. This must be done in either the hospital or the clinic—alone or in collaboration with the scientific community. Programs that demand change in the functions of physicians and other personnel call for refresher courses and further training at all levels.

In the discussions on aftercare services, concern was expressed about the danger of discontinuity of responsibility for the patient's care. There was some confusion of terms, and great differences in available resources were obvious. But as Dr. Stokes emphasized, "You must use what you have to work with."

In general, it seemed that, treatment, work and job placement, and school placement, were organized, staffed, or supervised by the hospital, while such services as recreation, housing, and general socialization were run by other community agencies, with the hospital staff supplying the patients and acting as consultants to the agency personnel.

From all this I tried to pull out this general theme: *that some community agency must accept responsibility for coordinating the vast area of community services necessary for a community health program—and that the hospital should be this agent.* To do so the hospital staff must win the respect of the community by its own therapeutic program and have an adequately trained staff to do the community task.

Even in counties with meager, practically nonexistent programs, the way to start is to set up some central agency, some general focus from which collaboration with other agencies can develop. This conclusion came out of your discussions. I have gathered the impression that you are well aware that we have to assume this role of leadership, and that the hospital staff must win respect—that we must have adequately trained persons to do this necessary community work.

Old, long-term, oversized hospitals, like some long-term patients, suffer certain residual defects. Our best hope for improvement is to concentrate on their residual assets and use them to further the program. In managing the long-term schizophrenic, you can increase his symptoms by concentrating upon them, so that he will continue to talk and act like a schizophrenic. Or you can concentrate instead upon his positive assets, and he will begin to move in therapy. In handling our hospitals this is what we have to do—concentrate and strengthen the good points and present a program directed toward expanding and developing our residual assets.

So often we get so involved and overwhelmed by the complex problems of our social system that we forget to lift our heads and look about us. If we look around, we will find that there are often simple and obvious solutions to what seem to be insoluble problems. •

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1. Morrison, J. E.: Hospitals *33*:97 (July 16) 1959.
2. Laitner, W.: Psychiat. Quart. Suppl. II *29*:190, 1955.

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PSYCHIATRIC-LEGISLATIVE PANEL

Co-moderators: MATHEW ROSS, M.D., and MR. SIDNEY SPECTOR

Panelists: PAUL V. LEMKAU, M.D.
HAYDEN H. DONAHUE, M.D.
WALTER E. BARTON, M.D.
THE HON. J. S. HALL
THE HON. JEROME ROBINSON
THE HON. GEORGE D. CLYDE

THE FINDINGS of the psychiatric-legislative panel indicate that, after five years of relative quiet on the legislative front, mental hospitals must again prepare for the "battle of the budgets." Despite the increasing need for more and better trained personnel and for newer treatment programs that will cost even more money, active public interest in mental health is waning, and legislative apathy may soon follow.

Why is this happening when so recently psychiatry and mental illness were in the center of public attention?

Unfortunately, explanations of the fickleness of the public conscience come no easier to psychiatrists than to other groups whose endowments are won by tugging at the frayed strings of the public purse. Basically, hospital psychiatry seems to be going through the down-phase of a "cycle of public interest." The five years of movement which began in 1955 are apparently being replaced by a "consolidation-of-gains" movement which is less actively concerned about mental illness. Public reactions to the shameful conditions uncovered by the exposés have worn off, and psychiatry's praise of the tranquilizing drugs has actually helped to lull the people a little further toward complacency.

The urgency of political promise in the field of mental health is softening. In the recent past, as a result of two political parties vying for advantage in an area of reawakened national interest, practically every candidate's platform joined the attack on mental illness, and hospitals were indeed thankful for elections and for campaign promises. Today, as political interest is diverted elsewhere, tax reduction, fiscal policy, and the hard-pressed state budgets are taking control.

While hospitals cannot hope to stir the public mind continuously with perpetual crises, they have failed to keep themselves in the forefront of civic affairs through normal channels of communication.

Legislators claim that turtle-shell policies within some hospitals—inflexibility in administration, and unresponsiveness to the outside world—have not helped to win friends, or legislative votes either. Because of their dedication to their jobs or fear that the outside won't understand the workings of the institution, hospital people remain aloof to the government and the community and sometimes forget that they work for the people of the state. Perhaps through sheer lack of time, hospital administrators fail to develop the direct approaches to good legislative relations—personal contacts with legislators, government administrators, or the governors.

COMMUNICATIONS PROBLEMS

On the other hand, psychiatrists accuse legislators of being insensitive to changing psychiatric concepts and the increasing demands made on mental hospitals. They find it difficult to get legislative people to come into the hospitals, which makes it very hard to keep them up-to-date on the changing goals of psychiatry. For instance, there is the current problem of convincing legislators that the decrease in hospital populations actually calls for higher per capita appropriations because of increased admissions. Psychiatrists feel that money should be allocated in proportion to treatment rendered, rather than to the number of patients remaining in the hospitals.

Although mental health expenditures have tripled over the past ten years, the hospitals are, in some cases, actually receiving a smaller percentage of the total budgets because the entire cost of government has gone up.

Psychiatry is going to need a bigger share of public funds to fulfill its goals of maintaining fewer patients in the hospital, treating them for short periods, and then discharging them. It will take more money to attract new personnel into mental health work and to train them, because, under present budget conditions, the manpower problem is getting worse instead of better.

And there are the constant problems of replacing or remodeling worn-out facilities, and the need for research into mental health problems.

Legislators and psychiatrists agree, however, that better communication between hospitals and legislatures would alleviate many of their differences and make solutions to their financial problems easier. Moreover, such communication might steady the fluctuations of public interest by keeping the subject of mental illness politically alive.

One of the first steps in building good communications is to educate legislators and governors, who make the budget recommendations, to think in psychiatric terms. At the same time, hospital people must make an honest effort to understand the thinking of the legislators. In this way the basic problem of deciding what *can* be done for the mentally ill, as opposed to what medical people think *should* be done for them, gets the benefit of dual concern. Ideally, then, a budget would not be fought over on the floors of Congress, but would be mutually discussed and approved during its writing.

A major difficulty in this education process is the lack of a suitably located, stable classroom. Aside from the breakdown of communications caused by political turnover from one election to the next, there are the fundamental problems of time and distance. State hospitals are too isolated from the civic and social community to be reached easily by legislators. How this educational relationship is to be established, then, will depend on the ingenuity of the hospital administrator in overcoming the problems particular to his hospital. A superintendent at one hospital sets aside Wednesday morning breakfasts and tours of the hospital for legislative and budget people. A good many of them accept his invitations. Another effective method entails the use of group responsibility and group action. Through the various professional, scientific, and academic organizations with which the hospital may be associated, contacts are maintained with legislators, governors, and members of the public.

Hospitals have discovered that truth and honesty can be helpful in legislative relations even when they hurt. The structure of the mental hospital is often such that only those people inside it understand what is really needed; to effectively communicate these needs demands almost complete honesty.

Of further importance is the value of speed and accuracy in meeting the hospitals' obligations. All legislative requests should be filled promptly, and wherever direct contact occurs with legislators and budget administrators, the impression that the mental hospital is thorough, efficient, and progressive must be left in their minds. This same impression should be fostered in the public mind through community contacts. In this way, the people will understand and respect the problems of the hospitals and be more inclined to elect political candidates who will be receptive to hospital needs.

The importance of preparing comprehensive, concise, but simple budgets for legislative approval cannot be overemphasized. For many legislators, the hospital budget proposal may be the only source of education and information about the hospital. If the proposal is clear-cut, and its allocations specifically outlined, there is less chance for doubt as to its validity. It might also benefit the hospital to have at least one friend in the government, who knows the ropes, to see the budget through the legislature.

Legislators examine budgets from many standpoints. Although public interest does influence them, and the amount of interest relates directly to the funds allocated, legislative people like to see some evidence of production for dollars spent. With only a certain amount of public money available, they must invest it for the taxpayers as wisely as possible. The newer concept of the word "economy" which defines it as the wise, proper, prudent use of money is not universally accepted by legislators. The older cash-register philosophy (what goes in must come out) still prevails. For this reason, although they recognize the need for new and different approaches to psychiatric treatment which may cost more money, legislators still want hospitals to explain why old programs of treatment have not worked and why the hospital's promises of last year have not been fulfilled.

BUDGETARY DYNAMICS

For his own protection, then, the hospital administrator must try to propose a budget which is fair, honest, and, most important of all, justifiable wherever possible. This does not mean he should cut his budget or the hospital's efforts just for the purpose of economy, or that he should pad to protect against a cut. It means that the proposed budget should reflect his best judgment of the hospital's needs; then the responsibility for the budget passes on to the legislature.

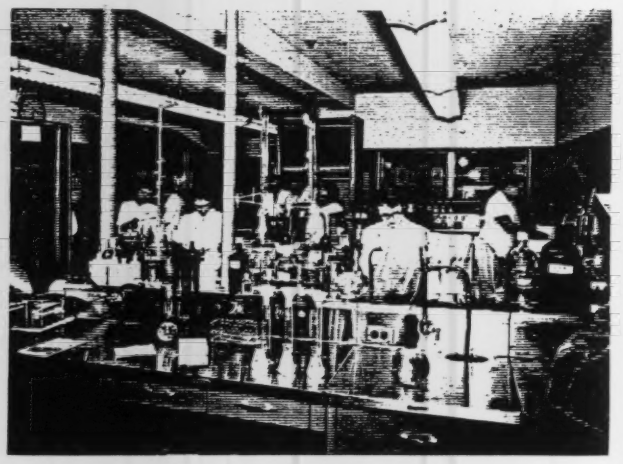
If the budget is passed there is, of course, no problem. If it is cut, the hospital is faced with the sternest test of its legislative, and public relations. The hospital administrator may realize that the cut is final, and that nothing else can be done, but that doesn't alter his physician's responsibility to the patients under his care. Depending on the severity of the cut, he knows it will be that much tougher to do the job, and that much harder to keep his staff intact. As a medical man under these circumstances he considers it his duty to argue, but the legislature feels that once a decision is made, the hospital must abide by it without excessive complaint. There is no answer to this problem that would apply to all situations, except that the administrator must decide carefully when to fight and when to "wait till next year."

Near the end of the discussion one panel member brought up the subject of political patronage, and its use in state hospitals. Almost unanimously, panel members agreed that a politician's reference is not a qualification for employment in a mental hospital, and that political wards should be required to meet the same qualifications for a particular job as other applicants.

One of the doctors on the panel, reflecting the light of legislative experience that had dawned on him remarked quietly, "You might ask (the politicians) for someone who knows the ropes and can help you keep your nose clean . . . somebody who knows the political situation. . . ." •

SIMULTANEOUS SESSIONS

ORGANIZATION FOR RESEARCH:



The Experience of The 16 Southern States

W. P. HURDER, M.D.
Discussion Leader

THE SOUTHERN REGIONAL EDUCATION BOARD was established in 1955. At that time its sixteen constituent-states had grants totaling $600,000 for mental health research, from either the Federal government or other national granting agencies. By 1960, the research funds from these sources had grown to approximately $3,000,000, and six of the states had begun to set aside money themselves for mental research. It can be assumed from this experience that considerable research funds are available if enough attention is devoted to finding and attracting them.

The basic difficulty in getting research projects under way in mental institutions is hospital people's lack of knowledge about research and resources. In addition, hospitals are overburdened with staffing problems, lack of time, inadequate facilities, and too little money. Coupled with the personnel's hesitancy to learn how to set up a simple research problem, these factors actually prevent many hospitals from capitalizing on the extra staff, funds, and public interest that might accrue if such a project were conducted.

Another problem is how to solicit state action. Research should begin at the state level; once this is initiated, other agencies, including the Federal government, can be approached for funds. National agencies feel that it is the states' responsibility to sponsor such research, and that grants should be awarded on a competitive basis to the best ongoing programs in the field. (Another significant SREB development was the fact that half of the southern states now have people specifically assigned in the departments of mental health to coordinate research programs.)

A look at the problems of mental health research from the point of view of the states themselves, however, makes it easier to understand why progress has been slow. Some states argue that they already have research units operating on the campuses of state universities. Others complain that even if the hospitals were allowed to do research, it would be of no real value since, in many cases, the investigations would be conducted by personnel untrained in research. Economy-minded states answer pleas for research funds by pointing out that there is hardly enough money to maintain the patients under minimum standards of care.

The states with these attitudes shut themselves off from additional funds that might be forthcoming from the Federal government or from independent granting agencies. In effect, they lessen the chances for the development of new and dynamic programs of care that might in the long run be less of a financial drain on the public.

SUPPORT FROM SCIENTIFIC BODIES

Although the states must furnish the impetus for research development, national associations, professional groups, and other scientific bodies should make available the knowledge needed to initiate and support sound

research policies. They should be willing to participate in training state research directors and other research people, through workshops, seminars, consultation, etc.

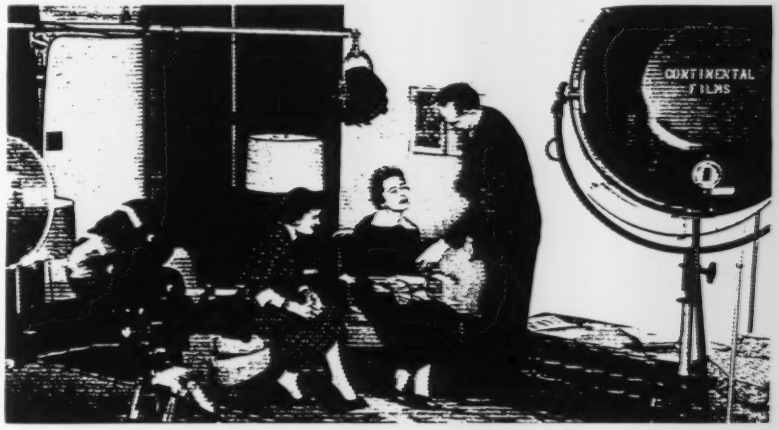
Research projects in state hospitals could, of course, be of several kinds. Programs can be small enough to be conducted by one or two people in their spare time, or large enough to require that an entire hospital be designated as a research institution. In any event, adequate research facilities should be available and conditions should be favorable for the type of program to be undertaken.

Research in mental hospitals should not disrupt normal medical routine. Similarly, once a project is in progress, it should not be stifled by saddling research personnel with more hospital duties than would usually be expected. In many cases, the introduction of research procedures into the hospital atmosphere actually promotes more efficient use of regular staff.

Those who are contemplating hospital research-projects would do well to read the book that was directly quoted by the discussion leader in his remarks to the group, *Mental Health Research in the South on the Threshold of the Sixties,* (available from Southern Regional Education Board, 130 Sixth Street, N.W., Atlanta, Ga.) Some very basic information on current research is also available through the Bio-Science Information Exchange, in Washington, D. C. This Federal agency will furnish a list of 200-word summaries of all nationally supported research going on in this country which pertains to mental illness.

FILMS AS EFFECTIVE TEACHING TOOLS

HOWARD P. ROME, M.D.
Discussion Leader



To SOME PEOPLE films are a form of entertainment and relaxation. To others they are a gripping experience with the arts. To yet a third group, they are a means of enlarging knowledge or learning to perform certain tasks.

For psychiatry the film has to be all of these things –entertaining enough to hold the audience, dramatic enough to impress a point, and interesting enough to help teach a subject. Depending upon the intended audience–lay public, a group of interns, or hospital patients–it will have to contain varying amounts of each of these elements. In psychiatry the film has a very definite place, and a very planned direction, and it is most commonly used to teach or to train.

NO SHORT CUT TO TEACHING

However, as the discussion leader pointed out, the motion picture is not a "quickie" short cut to the problem of teaching. Films have nothing that good teachers do not have. The advantage is that they can be made to say very precisely what it is you want them to say and will say it over and over again.

During the Institute, many people alluded to the possibility of trying to decrease the social and emotional distances among people. Here is a good way of taking people by the hand, and showing them the interior of the hospital in a short time, and in precise terms.

Information, neatly packaged in a motion picture, has a connotation of authority with a minimum of pain. An air of anticipation is associated with entertainment, and films and entertainment go together like ham and eggs.

Films can avoid the deadly dullness of stereotyped teaching. The business of verbally grinding out information is not as effective as a film which can use a variety of moderators to get across information. You can multiply the kinds of interpretation you have and get the message across with less resistance. The film can be made to say anything you want, using any kind of technique. The time sequence can be of your choice and making. But the film has to be flawless.

The background figures can be incorporated in film, carrying purposefully effective undertone, music reference, etc. You can create a context in which the message is carried, and the context itself can get your points across. A number of subtle messages can be carried

through a variety of channels, creating a whole panorama of situations.

Emotional conflict is a different breed of illness from, say, measles, which you get and get over. Mental illness is a way of life involving compensation and decompensation, which can be very explicitly illustrated in a film. A psychiatric film, intended for people unsophisticated in this field, must present some idea about the processes which take place in mental illness, yet at the same time, give the audience some conception of mental health. Films with dramatic content can help accomplish this.

Such films as "The Battle of Britain," "The Swedes in America," and others were used for the dramatic purpose of eliciting some sort of rapport between the makers and watchers of the film. With each presentation, social distances and emotional imbalance can be overcome by this means of communication. Because we believe that distance can be bridged by the use of mental health films, we have resorted to dramatic presentation.

The film can be accepted or rejected by an audience, depending upon the form in which it is packaged. A good testimony to this is the growth of adult television wherein complicated mathematical theories have been made fascinating.

Remember the great hue and cry that arose about the use of comic books to get across information? This means was thought by many to be a tawdry way to convey the precious message they wanted to communicate. The use of paperback books, heretofore entombed in hard covers, is now acceptable communications procedure.

We were certain if we could package our films suitably, we would be sure of a greater amount of audience receptivity. In the beginning we made the mistake invariably made in using mass media—we thought of a *substitute* for a good didactic presentation. However it is simpler and easier to let a fellow lecture than to spend $12,000 a minute to take a picture of him lecturing.

Alice Keliher had taken sequences from popular films, such as one of Spencer Tracy and Freddy Bartholomew in "Captains Courageous," and used them as catalysts for human relations discussions. But, there was no useful film agency for PTA, mental hygiene groups, service club groups, and the increasing number of nurses and psychiatric students.

Psychiatric teachers theorized that they could borrow some of the fascination inherent in dramas such as "Death of a Salesman," "A Streetcar Named Desire," and "Hamlet." They can use these portrayals of human conflicts most effectively. A case-history will only bore everyone with details and devitalize what is really worthwhile or unique. Relatively few people are so creative that they can infuse case-histories with drama merely by reading. If everything which transpires in psychiatric teaching is essentially therapeutic, then there should be an emphasis on interpersonal exchange. And what better opportunity is there to stimulate this than by dramatic presentations?

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A film is like literature. It is a collection of symbols to evoke a certain type of response. Since the film is more or less symbolic, the producer and director can use a certain amount of literary license..

The question of literary license, however, presents a dilemma, for in order to get a hospital film dramatic enough to present, countless practice shots must be taken of patients, or else regular actors must be used. Sometimes the film may be held up six months just to get the proper patients for the role. In order to get real situations, about 18 hours of footage must be shot to come up with a 30-minute film.

In the film "Man to Man," the producer went into the hospital and stayed for two or three weeks, meeting several hours daily with the aides who were to impersonate the patients they knew at the hospital. Before the film started, these aides would sit around and project themselves into the roles of the patients they were to portray. Some people felt the result was almost too realistic! The films, "New Light on Darkness" and "Booked for Safekeeping," are examples of ones using real people for character roles. Since there is an increasing emphasis on giving up-to-date reports on what psychiatry is doing for the mentally ill, these types of films are becoming more commonplace.

ANIMATED CARTOONS

Another type of film on the uptrend is the wholly- or partially-animated cartoon, which can be used well in lecture films to italicize certain points. One such film is "The Appraisal of Competency," which uses the cartoon character, Dr. Whatsisname, and other similar characters to get across a highly technical point in a most facile manner.

Certainly all these technical and realistic variations are essential, but as a teaching device the film must be shown to people who will have had the experience to comprehend it, and who will be interested in it.

For example, the new English film, "There Is a Door," is not totally accepted by many audiences in the United States because it advocates things which are not standard policy in this country. One doctor mentioned that during World War II, Marines were shown a campaign fatigue film about the effects of long periods of time in the jungle. They saw it, but couldn't accept it, because they didn't have the experience to understand it.

It is most important that the right film be selected for the right group. Many films are devised only for certain groups, and therefore should be used only for them. There are manuals available telling of the suitability of specific films in different situations. For instance, some groups may not recognize today the significance of what may have happened 20 years ago. One excellent method of helping them would be to show the film "The Long Night," which illustrates the import of past experience by portraying the problems of a young girl in her relation to men, and subsequently her adult relationship with men. It gets the point across and viewers can see the relevance.

In showing any film, however, no matter who the audience, the teacher or leader must realize that films cannot stand alone as teaching devices. Substituting films for teachers is not realistic. Rather, a film should be considered as a visual aid in the same way a blackboard is—or as a catalyst to stimulate discussion. One doctor mentioned that prediscussion is just as important as postdiscussion, and that oftentimes films do not successfully communicate unless there is a prediscussion. Certainly the discussion leader or teacher should see the film himself before attempting to show it to an audience, and some instructors even go over the special features in their minds while the film is running. Thus they will be prepared to stimulate discussion and anticipate any questions the audience may ask.

PREPARATION AND TIMING

What would happen to the unprepared teacher if the projector should suddenly collapse? He must always be ready for a situation like this, so that he will be able to fill the gap effectively.

Another "must" is proper timing—selecting a film that will not take up so much of the meeting time that there is little or no room for pre- or postdiscussion. The value of the learning experience is lost if discussion of the film is held over until the next meeting.

The motion picture is a highly malleable tool in the hands of a good teacher. It can be seen at a dynamic or purely informational level, depending upon the viewer. The teacher can read into or omit what he chooses. If it is properly integrated into the lecture curriculum, the film is beneficial but cannot be used as an excuse for nonpreparation on the part of the teacher. The film is often that needed extra, however, which allows the fair teacher to become a good teacher.

Probably the most important and certainly the most interesting phase of the film-showing process is the discussion after the film. Films provide a wonderful scapegoat for displacement of all kinds of feelings about the teacher and the class. If the teacher appreciates this effective interplay, he understands that films have the capacity to provoke all kinds of feelings.

STIMULATING THE AUDIENCE

Although most films do create some feelings, the viewers don't always jump into the discussion as the teacher would like. This may be because of the anxiety created by closeness. The group may suddenly become rigid and immobilized. Dead silence prevails, because no one wants to break the ice. No one will, either—unless the teacher begins. Suddenly comments will begin and the discussion is on. The teacher will be able to interpret at two levels—the manifest and the latent content of the film.

One discussant told of his experiences in showing "The Snake Pit" to a PTA group, with the idea of trying to drum up interest in a local mental hygiene society. The film aroused much feeling. The teacher didn't really care what kind of feelings because he hoped ultimately to channel the discussion along the desired lines.

A psychiatrist mentioned that he had experienced the chance to use feelings provoked by a motion pic-

ture to find out a great deal about one particular patient. After showing the film to a patient-group, he had the choice of sticking with the film, or going off into the personal problems of one patient. He chose to use the film as a catalyst to induce the patient to begin talking about himself.

MATERIAL FOR PANEL DISCUSSIONS

Films can also be used as subjects for panel discussions between all types of groups. One hospital shows films to patients on the wards after which there are panel discussions between staff and patients.

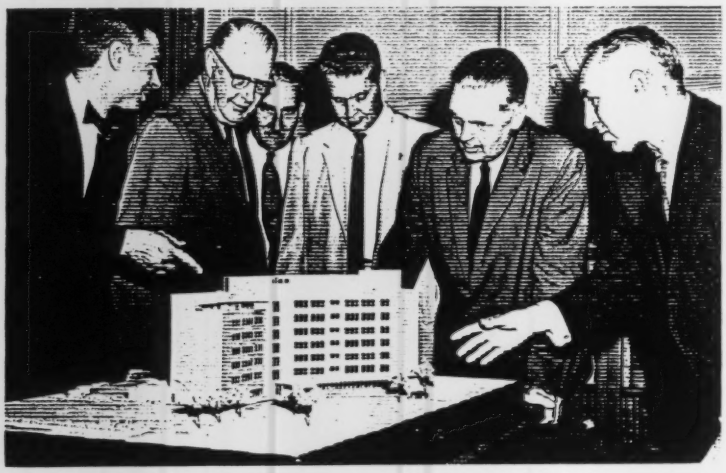
Just as it is a teaching device, the film is also a training device. Staff members can be taught numerous things by seeing them on film. One film teaches the technique of electroshock, and can be shown to, say, a group of interns, who have never seen this type of treatment. After seeing the movie of this procedure, they will, when they see it applied in actuality, feel that they have been there at least once before.

Many people are beginning to see that the film is not just a one-time experience, to be sent away after being used. A great deal of money is spent to pack a great deal of material into a 30-minute film, so that it becomes a rarefied package. One group of nurses was told to show the same film to the same group every week for six weeks. After the second time, they protested. They were told that this was not much different from seeing the same patients again and again but having different levels of information appear each time.

Another device is to run a film once with only the picture, and again with only the sound track. This focuses attention first on vision and then on words and sounds. This material was used in showing "Bat Room" to a group of medical students. After they had seen it with picture only, they were asked who was a paranoid, etc. The students replied, and then saw the film again with sound to check their conclusions.

Today, psychiatric teaching and training films are more in demand than ever, and the supply does not always meet this demand. There is a need for more films about the mentally deficient, more films to teach correctional officers care of psychiatric patients, and many other types of films. Catalogues are available at most hospitals, and many mental health associations, state agencies, and universities have film libraries. The Mental Hospital Services Film Library is one such source. •

DISTRIBUTION OF FINANCIAL RESPONSIBILITY



MR. H. FORSTENZER
Discussion Leader

FINANCIAL RESPONSIBILITY for psychiatric treatment and care should ultimately be distributed so as to facilitate the development of an effective over-all program for *controlling* mental disorders in the population. However, to build a financial structure broad enough to support such a community-integrated program of mental health will require sweeping and tradition-shattering changes in current financial practices.

Specifically, changes must be effected in the organization, scope, and support of mental hospitals; in the laws governing admissions and releases, etc.; and in the types and quantities of community services. In conjunction with these changes, the following medical developments might also take place:

A. *Continuity of care or continuous treatment to shorten the duration of episodes of hospitalization and breakdowns.* To be achieved by improved communications among all state and local, public and voluntary services and facilities by linking them together through joint use of personnel, and by facilitating the movement

of patients among the different treatment services.

B. *Acceleration of the changing role of the mental hospital from custodial care to one in which the hospital performs distinctly medical functions in the whole range of services needed by those with medical disorders.*

C. *The "open" hospital with a "revolving-door" system closely linked to the community, in contrast to the self-contained total institution which attempts to provide within itself all the patients' needs.*

D. *Change in public attitudes toward hospitalization and psychotic illnesses.*

E. *Changes in admission and release procedures to reduce or eliminate judicial determination of place of treatment and to substitute medical determination.*

The biggest deterrent to the fulfillment of this type of plan, obviously, is the lag between technological change and legislative thinking on the subject of mental illness.

AN ANTIQUATED CONCEPT

Legislative and fiscal approaches to the care of the mentally ill are based on the nineteenth-century concept that the mentally ill are wards of the state—and 100 per cent state financial responsibilities. By custom, mental patients are "hospitalized," not so much because they are sick, as to protect society from them. Consequently, state financial policies for mental hospitals have been concentrated on problems dealing with personnel and facilities for physical confinement rather than for medical care.

Although mental hospitals have changed, and continue to change toward an intensively medical point of view, the bills are still being paid primarily by the states and according to the laws of "institutional" economics. And as long as the major type of service available to the mentally ill is completely state-supported, a community-integrated system cannot get under way. This lopsided distribution of costs results in serious program distortions and prevents progress in spreading hospital services into the community.

ITS VESTIGIAL EFFECTS

An especially harmful effect of state-support for the mentally ill has been its influence on the policy of the Federal government, which has virtually excluded hospitalized mental patients from all forms of Federal assistance. For instance, the recent program of medical care for the aged proposes to cover some forty days of psychiatric care, but *not* in state mental hospitals.

State mental hospitals are also excluded from most third-party payment and group health insurance plans such as Blue Cross, even though health insurance is a principal means by which individuals can cover the costs of their own medical care. Louis S. Reed, in an article entitled "Health Insurance Coverage of Hospital Care for Mental Illness" in the August 1960 issue of the AMERICAN JOURNAL OF PUBLIC HEALTH, in regard to Blue Cross, states:

"Under their most comprehensive contracts, as of January, 1958, of the 79 plans in the continental United States, 19 excluded all coverage of mental and nervous conditions in general hospitals and six covered only until the condition was diagnosed as a mental illness. The remaining 54 plans gave some coverage, but only 15 provided the same degree of coverage for mental and nervous conditions in general hospitals as they did for all other conditions.

"Of the 79 plans, 38 exclude all coverage in private mental hospitals and 41 in public mental hospitals. Only a handful of plans offer the same benefits for mental conditions in mental hospitals as they offer for general conditions in general hospitals."

In short, state assumption of the financial burden of caring for the mentally ill, although necessary in the past, has helped to separate mental illness from the rest of medical care. It has prompted state and local welfare departments to misuse and overuse the state hospitals as catch-all facilities. It has confused the issue of personal and family responsibility in paying for hospital services, thereby weakening the patient's incentive to get well and leave the hospital.

CHANGE THROUGH COOPERATION

It will require broad and extensive effort to change this pattern of fiscal support. As a beginning, a working partnership should be developed between community services and the state hospital systems. They can be strengthened and expanded. A major part of the change needs to be initiated at the community level, since changes are already occurring faster in state hospitals than in community services. One important step could be the development of community facilities as alternatives to hospitalization, a responsibility which the community has been somewhat unwilling to accept.

Programs should be developed that will allow psychiatric patients to be treated according to the nature of their illness, and closer to home. There must be facilities for short-term hospital care and for prolonged care. If the real need is for shelter, or for various types of nursing care, then it should be filled by facilities other than state hospitals.

The financing structure to accompany these changes cannot be clearly defined without more practical experience on which to base it. If the patient is to be cared for by the taxpayer, it makes little difference if the local, county, state, or Federal government does the actual disbursing of funds. The important thing is to insure that the money does the job intended for it, not whether the county controls this or that function, the state another, and so on.

All of the governments must work together to determine where financial responsibility for particular portions of an integrated treatment program should lie; i.e., whether local and county governments, should assume the cost of community facilities. The important thing, however, is that the entire mental health effort be medically unified in such a way that lines of communication, treatment, and development extend unbroken from the largest hospital facility right into the smallest one-man clinic.

Other sources of funds must be stimulated. Mental

hospitals need to explore some new avenues of finance similar to those of the general hospital, which is almost entirely supported by collections. Perhaps methods can be found whereby patients or their families pay at least part of the cost. Private hospitals might be encouraged for those who can afford them.

Efforts should be made to distinguish between which funds are to be used for mental illness and which should be used for welfare purposes. Some public welfare agencies are already making grants for boarding homes, nursing homes, etc. One hospital has moved its patients who are not in need of psychiatric treatment into nursing homes. The hospital agrees to share the costs with welfare agencies.

Obviously, the beginnings which have been made in establishing new patterns of financial responsibility seem sparse and inauspicious, but movement toward raising the second-class economic status of mental illness as compared to other sicknesses is nevertheless perceptible.

NURSING PROGRAMS IN THE OPEN HOSPITAL

CYNTHIA CURTIS, R.N.,
Discussion Leader

PSYCHIATRIC NURSES fill a need rather than a role—more precisely, the role depends upon the need—and today nurses are needed more than ever to work effectively in the open hospital. Consequently, nurses must assume new duties, new responsibilities, and new roles.

Since no two conceptions of the open hospital are identical, the nurse cannot expect to have the same duties as her counterpart in a similar hospital. To the discussion leader, the open hospital is a place where patients can come and go as they please, so that they will be able to assume responsibility for their actions while not at the hospital. However, this doesn't mean that every door in the hospital has to be open. Another opinion expressed was that nurses and attendants in open hospitals should go outside with the patient, thus offering patient-side care, rather than bedside care. Still another idea was that the open hospital, in some instances, is useless—that when many patients cannot get out of bed, there is really no need for open doors. Yet, no matter what the conception, there are basics which must be met and questions which must be answered.

First of all, what is the psychiatric nurse's position in the open hospital? The nursing service includes the nurses and attendant personnel. These people will have to work not only together, but likewise with all other disciplines, in order to provide the kinds of programs which will help create the optimum therapeutic climate. The nurse works under the auspices of a physician—thus as a student. She also teaches the dynamics of behavior, and works with nonprofessional personnel—thus as teacher and co-worker. Most importantly, she helps patients: helps them plan programs; teaches them orderliness and social habits; helps to bring patients together in natural groups; and she finds out where their problems are, and what caused them.

The nurse must act as liaison between every faction of the hospital. She must also coordinate activities. She has to effectively communicate treatment to the patient, and to those persons who are in the patient's environment 24 hours a day, with the ultimate goal of returning him to society.

WHERE DOES RESPONSIBILITY END?

Does the nursing process end here? It used to, and in many areas it still does, but the open hospital is not an end in itself, and cannot operate effectively without the community.

The questions then arise: How should the nursing service go about establishing good relations with the community? What is the relationship of the nursing service to the community after the patient is released? Do

nurses have the responsibility of communicating with other community agencies?

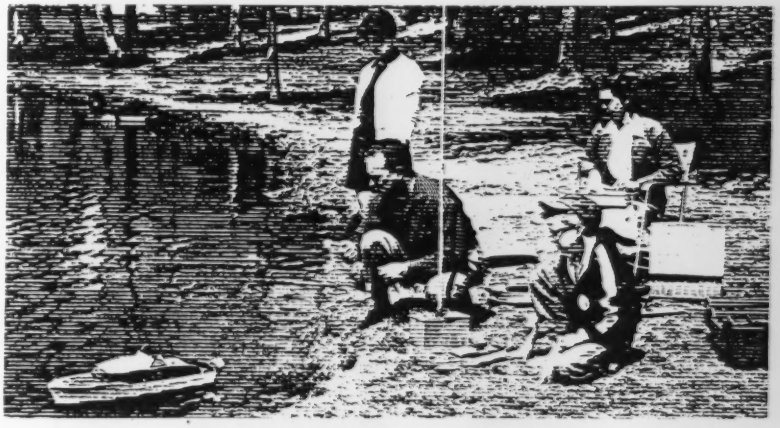
Again opinions differ, and there is no one single set of rules to follow, but the nurse has at her disposal numerous means and techniques. If possible, it might be helpful for the nurse to continue to see the patient after discharge. She can, of course, ask for assistance from the local public health nurse, and other responsible community agencies and outpatient departments. She has in her grasp the knowledge and means of relating her experiences about the patient to those in the community who will be responsible for helping him to adjust. And always, she can be a reserve counselor for everyone concerned with the patient.

Perhaps one of the best methods of summing up just what the various responsibilities can be is to describe some of the activities of a typical psychiatric nurse as she goes about her work. We shall use as an example a psychiatric nurse in a western state mental hospital, in charge of three wards consisting of about 20 attendants and 110 patients.

She is responsible for conducting joint patient-staff meetings. She works individually and collectively with the head attendants of each of the three wards. She helps to coordinate student nursing programs. She is advisor to the patient unit council. She meets with the discharge planning group which decides which patients are ready to leave the hospital. She helps the patient learn how to live in a nursing home. Then, when the patient is finally discharged, she can at last transfer some of her responsibility for him to those with whom he must live. It is up to the community now, but the nurse must always be ready to counsel, advise, assist, and give of her knowledge so that the community will have a better insight into the patient, and so that the patient will stand a better chance of returning to good health.

MANAGEMENT OF FAMILY TENSIONS

LEE T. MUTH, M.S.W.
Discussion Leader



MENTAL ILLNESS IN THE FAMILY has a shattering effect on all relatives concerned. So the questions arise: What can the hospital do to provide more support for these family members? What can the community do to help in reducing tensions? What can the hospital do to assist those to whom the relatives go during crises?

These are rightfully our primary concerns today, yet it is well to realize that the situation is not new, but merely an extension of problems that have existed since mental hospitals began. Nor is our concern for these relatives an innovation—rather it is an intensified revival.

As the group's discussion leader pointed out, psychiatry and social work have been concerned with the families of the mentally ill for at least 65 years—particularly since Freud's first work on hysteria in 1895. At the turn of the century, state mental hospitals began working closely with the families of their patients. Adolph Meyer, one of the foremost spokesmen for psychiatry in those days, felt so strongly about the family members that he sent Mrs. Meyer out to interview them in order to secure their cooperation. Psychiatric social work originated in state hospitals when persons were employed to work with families in providing aftercare service to the patient.

During the 1920's and 30's mental hospitals declined to such a point that they had their hands full in merely offering minimum services to their patients, and the families were forced to take a back seat. However, more recently, especially since 1950, the family has come to be a much more important element for consideration than ever before. This reawakening has occurred primarily because of two factors:

1. Research in the fields of sociology, anthropology, psychology, social work, social science, by such men as the Lidz's and their co-workers. Jackson, Spiegel, Acker-

man, Clausen, and those connected with the family study project in the National Institute of Mental Health are just a few of many who have made significant contributions to a more complete understanding of the family in relation to mental illness.

2. The increasing number of patients leaving our hospitals since the introduction of the tranquilizing drugs. This has made it absolutely necessary to provide more services to the families.

FACTORS IN FAMILY TENSIONS

Mental illness precipitates a variety of psychological and social problems which create anxiety and family tension. The extent and severity of these problems depend on a number of things. Which member of the family is ill? What is the estimated duration of the illness? How have tensions been managed over a period of time, not only in this instance, but in other crises?

All families feel the stigma of mental illness and fear it. They have feelings of guilt, hostility, and rejection, and these feelings affect every member of the family. Many will deny the fact of mental illness and often try to prevent hospitalization of the sick relative. They will probably withdraw from social contacts. When they finally do seek help, relatives usually turn to the immediate family. Even after hospitalization, most families will not seek professional help but will rely either on close friends or on people with whom they do not have a lasting relationship. Some few go to ministers or family physicians.

While the patient is in the hospital, the family continues to withdraw socially but now seeks help from the hospital. Relatives want to talk to the patient's doctor. Sometimes they can't see him, don't get the answers they want, or the doctor is unable to spend enough time with them. These relatives are not seeking help for their own personal problems—they want knowledge about the mental illness itself. They want to know about the treatment and what they can expect when the patient returns home.

EARLY MEETINGS WITH THE DOCTOR

It would be helpful, if, at the time of admission the families could meet the psychiatrist first individually, and later collectively with the sick relative and the social worker. They would then feel that the hospital was interested in helping them, too. Doctors' and social workers' offices could be on the admission ward, which would eliminate the communication problem at admission time.

While it is important to interview relatives, they may not always understand or even remember what the doctor and social worker have told them. Therefore, they would appreciate a reference booklet which would not only answer most of their questions, but might also eliminate some calls.

Often mental illness is a chain reaction of family tensions wherein one member becomes ill. For that reason, it is important to explain to a family how it fits into the patient's illness. To that end, some hospitals use movies, others hold family days.

Unfortunately, doctors do not have time to spend with families even though they would like to do so. When visits with relatives are possible, the doctor often sees that it is they who have caused the patient's difficulty. Usually family members show true feelings at the time of admission, but if an interview has to take place at a later date, they may hide their real emotions.

One VA hospital works with the wives of the patients through group interviews. In the beginning many wives were extremely hostile and, in some cases it took several individual meetings before they were willing to participate in the group sessions. In most instances, however, these sessions helped the wives and many of their conflicts were resolved. The VA Hospital in Gulfport, Mississippi, holds family forums twice a year. Each forum consists of six sessions, led by various hospital personnel. In this way, the family gets the feeling that the entire staff is interested in the welfare of the patient.

Often, relatives who ask questions are really trying to help themselves, but will not admit it. When they can accept this fact, they can be helped. One way of assisting unhappy relatives might be for them to do some kind of work around the hospital so they could actually see what is being done.

OVERCOMING DISTANCES

It is important for the hospital to work with the community. Most hospitals are faced with the problem of the family living a great distance from the hospital, so that services may have to be provided by community agencies or social workers. One doctor from Oregon said that about half the hospital patients are committed by the courts and that the family does not even accompany the patient to the hospital. The institution indoctrinates county health officers and nurses to its program since it does not have social workers. In several counties, the public health nurse sits in on commitment hearings and is able to explain some matters to the family. After the patient is admitted, the hospital report is sent to the nurse so that she can tell the family what is going on. When the patient is ready to be released, the hospital gets a report from the nurse to determine whether the family is ready to accept the patient. If he goes home for a trial period, the nurse checks to see if he is ready for discharge or if further treatment is needed.

Dr. Bowen of York, England, said that in his country it is usual practice for hospitals to work with the individual family. Patients generally come through the family doctor. England also uses public health nurses to a great extent. This is easily accomplished as the hospital is a part of the community and works closely with public health authorities. In addition, the psychiatrists get out of the hospital and work in the community, and in many instances patients are seen in their own homes.

It was the general consensus of the discussion group that much more support be given to the family of the hospitalized patient in order to help its members manage their tensions. This support can be given either by the hospital or by community resources. Unless the family is included in the therapeutic and rehabilitation plan, it is very unlikely that the patient will make an adequate adjustment when he returns home.

FINANCING ADMINISTRATIVE RESEARCH

MR. IRVING SHEFFEL
Discussion Leader

To say that there has been very little research done to improve the administration of mental hospitals is an understatement. Yet, at the same time, very little of the knowledge which has already been uncovered has been used. Research findings from other fields are not being applied to mental hospitals, although they are easily available from journals, periodicals, and other publications such as those on organization, personnel, administration, and management put out by the American Management Association.

Perhaps this basic lack in the exchange of research information would make a good subject for study. If the people working in mental hospitals had some idea of the myriad ways the same administrative functions are carried out in the different hospitals, it would be extremely valuable. This could be set up as a research project, to see what effect a certain amount of exchange of information would have on participating hospitals.

RESEARCH THREATENS

One of the reasons why research is not being done as much as it should in mental hospitals, and also why the positive results of other research are not being used, is fear. The word "research" frightens people. It implies the use of abstract theory as opposed to the practicality of learning by experience. And, sadly enough, there are people who are afraid of research because it means at least an attempt at progress. For instance, some people interested in doing research or in applying the results of other research to administrative procedures have been forced out of hospitals because the wrong person's job has been threatened by more efficient methods. This is unfortunate, but no matter how much care is exercised in the selection of a project, someone will feel that it threatens him.

This same fear, or mistrust, is at the seat of the conflict between medical and administrative groups regarding research. Medical specialists do not visualize administrative research as pertinent to the care of the mentally ill, mainly because determining the numbers and types of clinical people needed in any medical situation is their responsibility. The result is a sharp break between "business" and "professional" functions in the hospitals. For this reason medical administrators hesitate to allow funds for administrative research.

Administrative researchers maintain, however, that they are interested only in improving the lot of the professional employee. They want to determine how he can be helped to do his job more efficiently so that he can spread his efforts to more patients. They want to find out how the administration of the hospitals can be made a better adjunct to treatment. For example, lowering the overhead expense of medical care enables more care to be given.

The two main objectives of the group, as defined by the discussion, were: 1. To suggest problems for administrative research. 2. To explore means of financing it.

Choosing a problem for research is simply a matter of looking for an administrative procedure which might be done more efficiently. A basic question might be: Where can mechanization be used in the hospital, since machines do not require salaries, annual leave, sick leave, etc.? Are there better ways of handling, storing, and disposing of medical records? If medical reports were disseminated faster would it mean just enough added staff efficiency to treat one more patient?

In setting up a preliminary research outline, it is important to avoid duplicating work already done or presently under study in industry or elsewhere.

Research projects that try to establish staffing patterns are very important. How many personnel in what staff categories are needed for the different types of institution? This area of research is particularly pertinent

in view of the present trend toward dispersing hospital functions into the community. In establishing certain kinds of units, what can the hospital expect in the way of personnel and administration problems? How can hospital employees, both clinical and administrative, be better utilized?

Hospitals need to know how to obtain better performance from personnel by finding out what the standards are. For example, one hospital did a survey of the activities of attendants, and the relative costs. They found that 12 per cent of the attendants' time is spent on housekeeping. This meant that if one housekeeper were available for every ten attendants, the attendants could devote all of their time to patients. At the same time the hospital could save money, because housekeeping would be paid for at housekeeping rates rather than at the much higher attendants' salary. Another study conducted by the University Hospital at Ohio University showed that increasing the number of nurses beyond a certain proportion to patients on a ward does not improve care.

Hospitals need research evaluations of certain administrative functions such as laundry, food service, and maintenance that might be done better and less expensively by commercial enterprises. One hospital found that it saved staff time and money by having commercial interests pick up trash, and by purchasing its baked goods from an outside bakery.

Research pertaining to the more effective use of the budget as a tool of management and medicine could have far-reaching value. It would consider such questions as: What is the cost of treating and caring for the various types of patients from the time they are admitted until the time they leave? One hospital has already broken these costs down into sixteen units of measurement. For instance, its costs are $16 a day for treating schizophrenics. This research might also help answer such questions as: Why is it that some hospitals with the same types of patients, facilities, and budgeting, have better discharge records, etc., than others?

Financing an administrative research project does not seem to be too difficult, according to the group's experiences. In most cases, there are sufficient funds available from N.I.M.H. and other organizations to anyone with a carefully prepared and well-written research proposal in the mental hospital field. Ordinarily, there are two kinds of monies available: project development funds and money for carrying out the actual projects.

A most important implication in the group's findings lay in the fact that although there are funds available for administrative research, they apparently are not being used. The group was asked these questions: "How many here have been refused research funds?" and "How many have received money?" One person in the group had received funds from N.I.M.H., but no one had been turned down! This indicates that the lack of administrative research can be attributed not only to the lack of sufficient money, but perhaps more to the lack of motivation and resourcefulness. •

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PROBLEMS OF THE COMMUNITY IN INITIATING AND SPONSORING PSYCHIATRIC PROGRAMS

Panel:

MABEL ROSS, M.D.
THADDEUS P. KRUSH, M.D.
MRS. PEGGY LAMONT

SHOULD A COMMUNITY initiate and sponsor its own psychiatric facility on a do-it-yourself basis, or should there be central control and supervision by competent professionals from the beginning? This proved to be the heart of the discussion among the panelists in this group.

The moderator led off by pointing out certain common dangers which may be anticipated and obviated in the advance planning of community psychiatric facilities, regardless of the problems unique to each community.

1. *The danger of unrealistic expectations that all problems will be solved:* All community agencies concerned need to be represented on the planning committee, and each organization should have an opportunity to hear and discuss both the functions and the limitations of the proposed facility.

2. *The danger of domination of the planning by one group or person:* The power structure of the particular community should be considered, as well as the interests of the professional group.

3. *The danger of exclusively nonlocal support:* Some financial support from local groups is important even if adequate monies are available from a philanthropic or higher governmental agency. The eventual assumption of more of the financial support is often delayed by lack of local involvement from the beginning.

4. *The danger of inappropriate expectations of the professional staff:* Early discussion of the role of the new facility as a helping agency is very important, as is discussion of the role of each of the professional staff.

5. *The danger of establishing a stereotyped mental health facility:* The director and the staff should be apprised of the expectations and unique problems of the community.

6. *The danger of encapsulation of the mental health facility:* An advisory board to act as interpreter between the community and the staff is essential to the acceptance and success of the mental health service.

A community mental health worker, who came to the field through the American Association of University Women and stayed to spark a drive for a mental health center, described the difficulties encountered in starting such a facility. She saw the project as falling into four stages: Organization, Transition, Operation, and Continuation. The first phase was the stormiest and the most interesting, with a small but dedicated group of lay persons working for ten years against public apathy and the stigma surrounding mental illness. Finally this group, bored and disenchanted with talk, education, and study, launched into action by going directly to the county authorities and persuading them to budget $200 per 1000 population toward the mental health center. This persuasion was based on the hard-headed grounds of money savings for the county. Testing and treatment close to home involve less public expense than paying for such services in facilities many miles away.

Recruitment difficulties forced the sponsoring group to abandon its initial plan of hiring a competent psychiatrist as the first professional staff member for the center. Instead, a trained social worker with a local background was employed at a salary higher than budgeted. This proved to be the breakthrough. For the first six months this social worker did no counseling, but spent all of her time on planning and programing. The local college donated a building; two psychiatrists were hired, along with other personnel to provide a full staff; and the mental health center was on its way. From this beginning about two years ago, the center has handled almost 1000 patients, of whom some 200 are still in therapy.

PUBLIC EDUCATION IS CONSTANT

The Transition, Operation, and Continuation stages of the project were described as times of constant public education and re-education. The internal problems were less interesting and became the more routine ones of housing, insurance, employment security, vacation, educational leave, etc. Volunteers dropped off, and a new role had to be found for them as a liaison group between community and center. But mainly, through all stages, the ever-recurrent theme was the education of the community to its own mental health needs and to the services provided by the center.

From her experience, this panelist cited two main pointers for community groups considering the establishment of mental health centers. The first and most important is to recognize the crucial time when a commu-

nity is ready for such a facility and to act promptly. The second is to involve the community in every phase of the project, financially as well as otherwise, since the investment of local funds stimulates the investment of local interest.

The second panelist in this session described the organization of state-wide community services from the logistical standpoint and from the angle of professional direction. He pointed out that sickness is not determined by politico-geographic boundaries and that the finding of illness must be made by competent professionals in a medical framework of reference. Thus over-all services usually require some central control and supervision to set minimal professional standards and to determine professional goals and methods of procedure. He agreed with the first panelist that education and involvement of the community are imperative in aiding in the definition of community needs, problems, and varied attempts at solution. He also agreed that lay boards are desirable and necessary in community interpretation of services. However, he cited as advantages of the statewide, professionally-directed community services program the following: 1) better professional coverage of deprived or undeveloped areas; 2) establishment and enforcement of at least minimum professional standards in selection and supervision of personnel; 3) unification of effort through coordination of activities of different clinics; 4) two-way professional stimulation; and 5) professional control of the program. Disadvantages were felt to be: 1) lack of direct community involvement; 2) fostering "grass roots" dependency; 3) a more expensive administrative dollar in that it costs more to send the proper dollar to the state or national capital than to expend it at home; and 4) destruction of local initiative through too much central control.

MONEY FOR TREATMENT

The discussion at the end of the session demonstrated the group's concern with the practical problems of mobilizing community interest and recruiting professional personnel. Questions were raised as to sources of financial support, and one discussant took issue with the use of Federal funds for community programs, claiming that Federal investment leads to Federal control. The moderator stated in reply that the Public Health Service has as its purpose the stimulation rather than the control of activities. Others in the group were somewhat skeptical of this, and generally impugned the governmental dollar while lauding private funds. One participant, however, stated that the source of the dollars seemed of little consequence so long as they were applied to the job at hand—the treatment of sick people.

COMMUNITY ADMINISTRATIVE TRAINING PROGRAM

VIOLA W. BERNARD, M.D.
Discussion Leader

As THE ONLY CENTER presently providing the training to meet a requirement of the A.P.A. Committee on Certification of Mental Hospital Administrators, Columbia University finds itself in a paradoxical situation. It has all the necessary ingredients to turn out trained psychiatric administrators, except one—enough students.

Despite the fact that the A.P.A. committee now requires a year of specialized training in psychiatric administration as one of the qualifications for certification, very few psychiatrists have undertaken such training to date.

The leader of this simultaneous session, who is also the director of the Division of Community Psychiatry at Columbia, first described the course of graduate training which her division conducts.* This is a degree course (Master of Science) which prepares candidates for administrative posts in mental hospitals and in community clinics and various community mental health programs. The course has been in existence since 1956 when the United States Public Health Service provided training grants and stipends to enable three psychiatric centers. —Menninger, Yale, and Columbia—to offer this new kind of training. Unfortunately, both the Yale and Menninger courses have since been discontinued, and the discussion leader attributed this primarily to the difficulty of attracting sufficient numbers of qualified candidates for

**Ment. Hosp. 11:5:7-10, May, 1960.*

the training. This is due in part to the general scarcity of psychiatrists, which makes it complicated for state commissioners and mental hospital superintendents to release members of their staff for the year of graduate training. Nor can some of them afford to keep such psychiatrists on salary while they undertake the special course. However, the National Institute of Mental Health recognizes the importance of administrative psychiatry and has continued to make stipends available to American citizens. The Canadian government has also granted stipends for the program to three of its psychiatrists, and there are some additional stipend funds available at Columbia through a private foundation for supplementation of these governmental subsidies in special circumstances.

The Columbia program differs in several respects from those which were in operation at Yale and Menninger, and it may well be that one of these differences is responsible for its outliving the other two programs. At the New York school the administrative psychiatrists are included among several other categories of graduate trainees in one or another aspects of public psychiatry, with a distinctive combination of courses in each curriculum. Thus the scarcity of psychiatric applications is less damaging than at the other two schools where the courses were exclusively devised for the administrative psychiatry trainees.

The Columbia structure of training the administrative psychiatrist with trainees in other categories in public psychiatry and with nonpsychiatric medical administrator trainees is designed also to foster an integrative viewpoint rather than an isolated approach.

TRAINING DETERMINES APPROACH

The primary difference between the psychiatrist-administrator and the nonpsychiatrist-administrator is that the former constantly draws on psychiatric knowledge rooted in clinical training as essential to his administrative functions, while the latter has often had much more intensive training in the nonclinical and business aspects of administration. Recognition of this difference can lead to a fruitful division of labor between the business administrator and the administrative psychiatrist in a given facility.

The discussion leader described the rationale for including the teaching of administrative psychiatry within the division of community psychiatry. It hinges on a concept of the mental hospital as an intrinsic part of the entire network of community facilities making up a comprehensive mental health program for a given population. Further, instead of viewing administrative psychiatry and clinical psychiatry as competing disciplines, the staff at Columbia sees them as mutually supplementary and essential components of total care, sharing the common goal of improving the mental health level of patients. The application of clinical insight through the far-reaching effects of administrative function is one approach to the problem of reducing the antitherapeutic impersonality and dehumanizing aspects of public psychiatry, which has the challenge and potential to do so much more for large numbers of people than the one-to-one approach of clinical psychiatry.

At the end of the formal presentation, the members of this group raised a good many questions about the training programs which had been described. Several of these had to do with the over-all time required for training and the various modifications that might be made in terms of individual requirements. The leader stressed Columbia's readiness to be flexible and realistic about the needs of candidates, and to accommodate to their situation within the limits of providing good training. She cited the case of one psychiatrist who had resigned from a position prior to taking his training and wished to take not only the eight months of academic work consecutively, but the entire training in a twelve-month period in order to be ready for a new position. Arrangements were made so that he could complete his field-project requirement in a four-month period of full-time work instead of the customary twelve-month period of part-time project work during employment.

STIPENDS DETERMINED INDIVIDUALLY

Members of the group who inquired about stipends were advised to write to Dean Trussell at the Columbia School of Public Health and Administrative Medicine for specific information. In general, the discussion leader said, the stipends are also flexible and vary on an individual basis in terms of professional qualifications.

She described briefly the Master of Science degree course at Columbia for hospital administrators other than psychiatrists, but pointed out that these courses are not especially geared to the *mental* hospital administrator although some of the graduates do turn to that field after graduation. Part of their curriculum includes some mental health content.

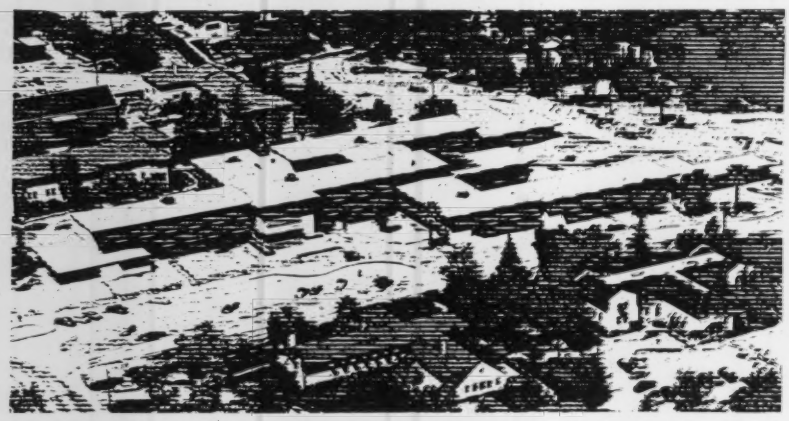
The leader expressed regret to the business managers in the group for stressing the training of administrative psychiatrists, but explained that her experience was exclusively in this area. One of the business managers spoke of the interest of the American Society of Mental Hospital Business Administrators in appropriate training courses. He said that Dr. Trussell had agreed to discuss with him some possibilities whereby the Columbia School of Public Health and Administrative Medicine could meet these training needs.

ADMISSION REQUIREMENTS

Several questions centered around the admission requirements at Columbia and whether all those who had completed approved training were accepted. The discussion leader explained that while approved completed training is the basic requirement, applicants must also evidence a genuine interest and aptitude for administrative psychiatry. The admission procedure includes an interview as well as a review of qualifications by an admissions committee.

Since 1956 twenty-eight psychiatrists have been enrolled in the courses at Columbia. Half have completed their training and half are still at some stage of it. No candidate has ever started the course and then dropped out before its completion. Of the twenty-eight psychiatrists, eleven have been or are in the administrative psychiatry program.

EVALUATION OF PRIVATE PSYCHIATRIC HOSPITALS IN COMMUNITY SERVICE



Moderator:
LAUREN H. SMITH, M.D.

Panel:
MARVIN L. ADLAND, M.D.
G. CRESWELL BURNS, M.D.
ALEXANDER GRALNICK, M.D.
RALPH S. GREEN, M.D.
MR. MELVIN HERMAN
JOSEPH L. KNAPP, M.D.
T. W. NEUMANN, JR., M.D.
IRVING J. TAYLOR, M.D.

"THE QUESTION OF JUSTIFICATION for the existence of private psychiatric hospitals has been raised. In my opinion . . . there is no justification for their existence unless they provide better care and treatment facilities than can be provided in public hospitals."

"The distinction of a community hospital and a hospital in a community should be clearly kept in mind. Private psychiatric hospitals are always hospitals in a community, but very seldom community hospitals."

"Greater relationships between our hospitals and the large state hospitals would be a good thing to achieve."

"Essentially it [the private hospital] renders a public service under private control—a common situation in our country—and helps American medicine preserve its private character. It may yet point the way ultimately to the completely private care of the mentally ill—far-fetched as this may seem at the moment."

So spoke the participants in the simultaneous session on the private hospital and the community. Talking from prepared papers, the panel members posed and answered questions ranging from whether a hospital can fix its role in the community by its own determination, to what to do with elaborate equipment in a private hospital which has outgrown its original function of serving as "an asylum for the relief of persons deprived of their reason." One panelist created a lively discussion by declaring that the operation of a hospital closed-staff is now obsolete; another pointed out the advantages of a private psychiatric hospital over a psychiatric unit in a general hospital; a third described the growing pains of a 40-bed private institution which emerged with a "more determined than developed program" for becoming a community psychiatric center.

The panel moderator opened the session by summarizing the goals of private psychiatric hospitals as follows:

1. To establish high standards of care and treatment for the mentally ill.
2. To encourage staff relationships similar to those in general hospitals.
3. To furnish psychiatric emergency service.
4. To furnish opportunity for inservice training.
5. To supply leadership in public education toward better mental health.

While there was general agreement with these goals, one panelist took special issue with goal No. 3 as it pertains to institutions which have selective admission policies. He contended that responsibility for emergencies, psychiatric or otherwise, must essentially remain with the community, and the way in which the private hospital can best serve the community is to persevere in the attempt to attain its own therapeutic goals. To admit specific cases purely because they are emergencies may interfere with the attainment of such goals and thus harm the community rather than serve it. He cited as a case in point his refusal to admit on emergency referral a patient who did not meet the hospital's admission criteria of being treatable in intensive psychotherapy and agreeable to remaining long enough for an adequate work-up.

The attitudes of the public toward the private hospital have a profound effect on the institution's ability to serve the community. Hence, the hospital feels a new obligation to inform the community about itself—to make its private position public. Specific public atti-

tudes and practices which are detrimental to the hospital-community relationship include the public's proclivity for suing the private hospital "at the drop of a hat" and the hospitals' corollary difficulty in getting adequate malpractice insurance; the lack of any organized communication between private hospitals and state authorities ("taxation without representation"); and particularly the unfortunate truth that even though there is a growing tendency to furnish some insurance coverage for mental illness, the sick person is denied this insurance if he enters a private psychiatric hospital.

The private institutions as a body stand prepared to render the community increasing service in every conceivable way, but there is much room for improvement: (1) in the manner in which the public views the private hospital, (2) in the manner in which the staffs of public and private hospitals work together, and (3) in the degree to which the psychiatric profession as an organized body supports, protects, and promotes the private as well as the public hospital.

BUILDING A PSYCHIATRIC CENTER

The private hospital with the "more determined than developed program," Falkirk, in Central Valley, New York, proceeded to establish itself as a community psychiatric center by several means. The licensed bed capacity was increased, the nonmedical staff was subjected to an intensive inservice training program, and the medical staff was expanded to include physicians whose combined experience made it possible to utilize all methods of psychiatric treatment. Rates were fixed at the lowest possible level, and the hospital's traditional policy of sending the patient home at the earliest point commensurate with sound practices was strictly adhered to and publicized.

Along with these internal adjustments Falkirk instigated an intensive community activities campaign and set up outpatient facilities at the parent institution, at the director's home, and in New York City forty miles away. With the cooperation of the County Mental Health Association, which had consistently ignored Falkirk as a psychiatric resource up to that time, the hospital published a directory of psychiatric facilities in the county and volunteered to prepare for the association a Mental-Health-Week press article on the development of psychiatric facilities in the county.

Monthly luncheon meetings, initiated for an exchange of information between hospital staff and general practitioners, drew a minimum response ("at the first meeting one G.P. attended, at the second none came, our one enthusiast being on a case"). However, they did produce invitations for the Falkirk staff to lecture before the staff meetings of two general hospitals.

Other community activities included a Hospital Career Day for local high-school students; staff presentations describing the hospital's work to the women's auxiliaries of the state and county medical societies; and two all-day conferences between clergymen and psychiatrists.

This hospital has been able to surmount the obstacles of distance and apathy to some extent. All distances are not too great and all groups are not apathetic. But the final yardstick will be utilization of the community service facilities of the hospital, and not the size of the audiences. Referrals are becoming more frequent but cannot yet be definitely credited to the community activities campaign.

Friends Hospital in Philadelphia, faced with a patient population of only 135 patients in a plant capable of handling about 200, has conducted a study of what to do with all the material at the hospital's disposal. Tentative plans call for building an office for physicians on the grounds; opening the staff so that patients can be followed both before and after hospitalization; expanding the geriatric services in such a manner that they can operate at less cost than they presently do; establishing an active outpatient service where anyone with a psychiatric problem can turn; opening the grounds to various community agencies to identify the hospital with the community; possibly giving 30 or 40 acres of the grounds to a general hospital of some sort. The superintendent described the future of Friends Hospital as unknown, but the possibilities unlimited, and likened the situation to that of the little boy who was drawing a picture in school. When asked by the teacher what he was drawing, he said it was a picture of God. "But," said the teacher, "nobody knows what God looks like." "They will," replied the little boy, "when I finish drawing my picture."

Another private-hospital physician expressed considerable doubt about the Friends' plan to provide better care for the aged at less cost, pointing out that adequate facilities cost more, not less, than inadequate ones. Speaking to the question of whether a hospital can determine its own community function, he described the growth of a hospital from a mere haven for people suffering from confusions and misperceptions, to a community institution with an organized aggressive program for a large number of patients. The steps in this evolution progressed from staff knowledge, gained through psychotherapy with patients, that there was a need for more than just a refuge. A community of a million and a half people had to be educated to the fact that there were no private beds for the acute and long disturbances of the aged. There were no adequate diagnostic facilities, and the custodial geriatric program was obsolete. A new psychotherapy program of not more than five years' duration was indicated. To accomplish this the hospital established an extremely thorough physical-medical program, and assembled a large competent psychiatric staff, with a cadre of social workers doing active social service work.

SUCCESS EMPHASIZES NEEDS

The end result of this program was the return of many people to the community in a family setting, even those who had been diagnosed as senile. This, however, only emphasized the need for follow-up care for these patients and for better understanding of the problems of the nursing-home operators. The former was accomplished through a psychiatric program which operates in effect as an outpatient section of the hospital. The latter was achieved by inviting nursing-home operators to at-

tend meetings and exchange their views with the hospital staff.

Another private psychiatric hospital, Beverly Hills Sanitarium in Dallas, Texas, has established a policy of serving as an information center for the public, the medical profession, and various community agencies. A senior staff member answers all questions, either over the telephone or in personal conversation. Further community services rendered by this hospital include talks on mental health by members of the staff to requesting groups; psychiatric and psychological evaluation of all pastoral candidates for the Episcopal diocese; all of the outpatient electroshock therapy for a number of local psychiatrists and for the state mental health clinic in the city; psychological tests for referring physicians, agencies, and occasionally the courts. Until recently the hospital had one of the few electroencephalographic facilities in the area and handled all of this type of testing for referring physicians and the schools, as well as for the large state hospital thirty miles away. Working relations between the two hospitals are excellent and the State institution accepts all voluntary patients referred by the private hospital, with only a personal telephone call necessary to make arrangements.

ADVANTAGES OF PRIVATE HOSPITALS

In discussing the advantages of a private psychiatric hospital over a psychiatric section of a general hospital, one of the panel members pointed out that the private hospital is able to take care of a greater number of acutely ill patients, who pose too much of a problem for a psychiatric wing of a general hospital. Such patients would have to be sent to a state hospital if private facilities were not available. Psychiatrists in private practice are particularly glad to have access to a private psychiatric hospital when they are called upon to care for a greatly disturbed patient.

This panelist stated that in his experience there are many modern well-equipped private psychiatric hospitals that provide care and treatment at a cost far less than is offered by general hospitals. The Blue Cross coverage is not, however, as good as in general hospitals—a situation which he believes will be remedied before too long. He cited as the prime advantages of the private hospital the closer doctor-patient relationship and, in fact, the close relationship that the patient has with the entire staff. Because of the homogeneous structure existing in a specialty hospital, attitude therapy can be more effectively utilized and brought into effect, not only on the part of the psychiatrist, but also on the part of the psychiatrically trained nursing personnel and those working in the occupational, recreational, and hydrotherapy departments. Thus illnesses of a more severe nature can be handled more deftly and those patients requiring longer periods of therapy will fare better.

He summarized the specialized facility's advantages over the psychiatric section in a general hospital as follows: (1) a more homelike, peaceful environment; (2) the ability to care for a greater number of acutely disturbed patients; (3) provision of care and treatment at lower cost in many instances; (4) greater flexibility in treatment programs; and (5) a wider range of therapeutic measures, especially for patients with refractory symptoms requiring a more extended period of hospitalization.

In their general discussion toward the end of this session the panelists disagreed on the subject of open staff for private psychiatric hospitals. The protagonists of the closed staff contended that it can successfully care for most patients and that an open staff would bring about undesirable discontinuity of treatment. One stated that his hospital contacted all qualified psychiatrists in the area and announced an open-staff policy. Now, three years later the situation is unchanged; the private psychiatrists in this area do not wish to follow their patients in the hospital but do wish them returned upon discharge.

One advocate of the open staff seemed to believe it worked best in a suburban situation. Another felt geographic location was immaterial but the open-staff policy was vital to the continued life of the private psychiatric hospital. He thoroughly disagreed that the private hospitals would eventually take over the entire care of the mentally ill, and pointed out that the public hospitals are improving and will improve so much that there will be no further need for private hospitals unless they adopt the open staff and the courtesy staff and unless Blue Cross increases its coverage.

All of the discussants agreed that there is great need for improvement in insurance coverage for patients in private hospitals. For instance, a good many private patients spend their entire treatment existence in a day hospital, for which there is no insurance coverage at all.

The members of the group were also in agreement on the great need for health programs for the aged. No other group of patients needs as much planning and care as the aged mentally ill. The state hospital is not the place for them, and the general hospital does not have the facilities. This might be the nucleus of a new kind of service which the private hospital staff could offer to the community. In this connection, working with nursing home operators has a great deal of promise.

PROOF OF NEED

One of the panel members summed up the general feeling of the session and placed it in historical perspective in the following manner:

Private psychiatric hospitals have served the public well for many years. Actually the first hospital in America to accept mentally ill patients was the Pennsylvania Hospital in Philadelphia—a general hospital. This was in 1752 during the Colonial Period. But general hospitals, on the whole, did not meet this responsibility. Thus, out of the dire need to serve the mentally ill and give these patients some measure of asylum, the private mental hospitals were established. These specialty hospitals have continued to spring up in growing communities where the need has arisen. Many of them have been in existence for several decades and still continue to give the excellent service that their founders intended they should give. This should be ample proof that a need exists for this type of psychiatric hospital.

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Bibliography *(11 clinical studies, 764 patients):*

1. Alexander, L. (35 patients): Chemotherapy of depression—Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. 166:1019, March 1, 1958. **2.** Bateman, J. C. and Carlton, H. N. (50 patients): Meprobamate and benactyzine hydrochloride (Deprol) as adjunctive therapy for patients with advanced cancer. Antibiotic Med. & Clin. Therapy 5:648, Nov. 1959. **3.** Bell, J. L., Tauber, H., Santy, A. and Pulito, F. (77 patients): Treatment of depressive states in office practice. Dis. Nerv. System 20:263, June 1959. **4.** Breitner, C. (31 patients): On mental depressions. Dis. Nerv. System 20:142, (Section Two), May 1959. **5.** Landman, M. E. (50 patients): Choosing the right drug for the patient. Submitted for publication, 1960. **6.** McClure, C. W., Papas, P. N., Speare, G. S., Palmer, E., Slattery, J. J., Konefal, S. H., Henken, B. S., Wood, C. A. and Ceresia, G. B. (128 patients): Treatment of depression—New technics and therapy. Am. Pract. & Digest Treat. 10:1525, Sept. 1959. **7.** Pennington, V. M. (135 patients): Meprobamate-benactyzine (Deprol) in the treatment of chronic brain syndrome, schizophrenia and senility. J. Am. Geriatrics Soc. 7:656, Aug. 1959. **8.** Rickels, K. and Ewing, J. H. (35 patients): Deprol in depressive conditions. Dis. Nerv. System 20:364, (Section One), Aug. 1959. **9.** Ruchwarger, A. (87 patients): Use of Deprol (meprobamate combined with benactyzine hydrochloride) in the office treatment of depression. M. Ann. District of Columbia 28:438, Aug. 1959. **10.** Settel, E. (52 patients): Treatment of depression in the elderly with a meprobamate-benactyzine hydrochloride combination (Deprol). Antibiotic Med. & Clin. Therapy 7:28, Jan. 1960. **11.** Splitter, S. R. (84 patients): The care of the anxious and the depressed. Submitted for publication, 1959.

Have You Heard?

NEW FACILITIES: Plans for the establishment in the State of New York of two new units for the care, treatment, and rehabilitation of narcotic addicts have been announced recently by the commissioner of mental hygiene, Dr. Paul H. Hoch. One 80-bed inpatient unit will to be set up at *Central Islip State Hospital,* Long Island, to serve the downstate area, while the other, a 20-bed inpatient unit, for the upstate area, will be located at *Utica State Hospital.* These new units will relieve the work load of the 55-bed unit established in 1959 at Manhattan State Hospital, Wards Island, New York.

The *Jacob E. Finesinger Building,* a $500,000 60-bed facility for emotionally disturbed children, was dedicated early this year at the Rosewood State Training School, Owings Mills, Md. The building is designed as a long-term, open-type psychiatric hospital for preteenage patients who cannot be helped by treatment in the community. Children, diagnosed as severely emotionally disturbed, psychotic, or borderline psychotic, as well as those having organic brain damage with emotional problems will be admitted.

The first stages of the Massachusetts 10-year *Blueprint for Better Mental Health* are beginning to shape up. This program was presented by the commissioner of mental health, Harry C. Solomon, M.D., in his 1960 report to the Governor, and described in his article published in MENTAL HOSPITALS [11: 14-17 (Oct.) 1960]. Money is now available and plans are being drawn for the building of two all-embracing community mental health centers—a 120-bed unit at Boston University and a 60-bed unit at the new Boston government center. These centers will serve both adults and children and will be geared to the rapid rehabilitation of the mentally ill. Three similar but smaller units are also approaching the planning stage. There are at present 18 community mental health centers in Massachusetts, but they serve children only. The 10-year project calls for 25 new community mental health centers for both children and adults and staff expansion of the 18 existing centers. Twenty-five new preschool nurseries for the mentally retarded and additional staffing of the existing 24 such facilities are also part of the long-range plans for Massachusetts' better mental health.

YOUTH GROUPS: Youngsters, from 12 to 20 years old, who call themselves the *Alateens,* meet together in small groups all over the country and abroad to discuss their common problem, an alcoholic parent, and to seek advice and counsel. Founded in 1957 in Pasadena, Cal. by the high-school son of an alcoholic, this is one of the least-known but fastest growing of teenage organizations. Alateen now counts 65 chapters in the United States, three in Canada, and two in Australia; fifty others are currently being organized in the U. S. Operating on the same principles as Alcoholics Anonymous, the youngsters are under the general guidance of Al-Anon, an organization for relatives and friends of A.A.'s.

Have You Read?

NEW HORIZONS IN PSYCHIATRIC HOSPITALIZATION, by Lauren H. Smith, M.D., in the November 12 issue of *The Journal of the American Medical Association.* "Psychiatric hospitalization is now regarded simply as a phase in the course of psychiatric treatment; for preventive and therapeutic psychiatry has emerged throughout social, family, group, community, and industrial areas. General practitioners are moving closer to comfortable adequacy in dealing with some psychiatric problems. The primary significant factor in successful treatment is the patient-doctor relationship. Not only psychiatrists but all qualified physicians must fully participate in hospital treatment as well as in home treatment, to the end that hospital care be available quickly and locally. In order to move toward this goal, psychiatrists and psychiatric institutions must end their mental, economic, and geographic isolation."

THE ADMINISTRATION OF LONG-TERM-CARE FACILITIES—This is a compilation of papers originally published in *Hospital Progress,* the official journal of the Catholic Hospital Association. They are adapted from speeches delivered at an institute on nursing homes, homes for the aged, and other long-term care facilities, held in 1960 at St. Cloud, Minnesota.

COSTS OF OPERATING NURSING HOMES AND RELATED FACILITIES, published by the U. S. Public Health Service, deals with another aspect of the operation of long-term facilities. This booklet cites costs from 36 studies in nursing homes, homes for the aged, and boarding homes under proprietary, nonprofit and public auspices.

The 36-page report lists 59 articles, pamphlets, and reports that have been published in recent years on cost and accounting records in special types of long-term facilities. It is available from the superintendent of documents, U. S. Government Printing Office, Washington 25, D. C., for 20¢ a copy.

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Diagnostic and Statistical Manual, Mental Disorders . . . prepared by the Committee on Nomenclature and Statistics of the American Psychiatric Association, 1952 ..... $2.00

Standards for Psychiatric Hospitals and Clinics, 1956 Edition (revised June 1958) for Public and Private Hospitals, Psychiatric Units in General Hospitals and Hospitals & Schools for the Mentally Defective $1.00

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Psychiatry and Medical Education . . . Report of the 1951 Conference on Psychiatric Education held at Cornell University, organized and conducted by the A.P.A. and the Association of American Medical Colleges, 164 pp., cloth, 1952. (Formerly $1.00)

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NEWS & NOTES

Quarterly Calendar

A.P.A. ANNUAL MEETINGS

1961 May 8-12, Hotel Morrison, Chicago, Ill. (117th)
1962 May 7-11, Royal York Hotel, Toronto, Canada (118th)
1963 May 13-17, Ambassador Hotel, Los Angeles, Cal. (119th)

A.P.A. MENTAL HOSPITAL INSTITUTES

1961 Oct. 16-19, Hotel Sheraton-Fontenelle, Omaha, Neb. (13th)
1962 Sept. 24-27, Hotel Americana, Miami Beach, Fla. (14th)
1963 Sept. 23-26, Cincinnati, Ohio (Hotel to be announced) (15th)
1964 Sept. 28-Oct. 1, Hotel America, Boston, Mass. (16th)

OTHER A.P.A. MEETINGS

A.P.A. Executive Committee, *March 4*, A.P.A. Central Office, Washington, D. C.

OTHER PROFESSIONAL MEETINGS

AMERICAN PSYCHOPATHOLOGICAL ASSOCIATION, Annual Meeting, *February 24-25* (Inq. F. A. Freyhan, M.D., Secy., 503 Medical Arts Bldg., Wilmington, Del.)

GUILD OF CATHOLIC PSYCHIATRISTS, *February 25-March 1*, Miramar Hotel, Santa Monica, Cal.

CONSOLIDATED VETERANS ADMINISTRATION HOSPITAL, North Little Rock Division, Annual Institute in P. & N., *March 2-3*, VA Hospital, Little Rock, Ark.

NATIONAL HEALTH COUNCIL, Forum and Annual Meeting, *March 13-17*, Waldorf-Astoria Hotel, New York City.

AMERICAN BOARD OF PSYCHIATRY & NEUROLOGY—Examinations for Certification in Psychiatry & Neurology, *March 20-21*, New Orleans, La.

AMERICAN ASSOCIATION OF PSYCHIATRIC CLINICS FOR CHILDREN, Annual Meeting, *March 22*, New York City (Inq. 250 W. 57th St., NYC 19.)

ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOANALYSIS—Annual Karen Horney Memorial Lecture, *March 22*, New York Academy of Medicine.

AMERICAN SOCIETY OF GROUP PSYCHOTHERAPY & PSYCHODRAMA, Annual Meeting, *March 22-24*, Barbizon-Plaza Hotel, New York City.

AMERICAN ORTHOPSYCHIATRIC ASSOCIATION, Annual Meeting, *March 23-25*, Statler-Hilton Hotel, New York City.

CARIBBEAN CONFERENCE FOR MENTAL HEALTH—3rd Annual Conference, *April 4-11*, University College, Mona, Jamaica, B.W.I. (Inq. Dr. Roy O. Cooke, Bellevue Hospital, Kingston, Jamaica, B.W.I.)

NATIONAL COUNCIL ON ALCOHOLISM, Annual Meeting, *April 5-7*, Shoreham Hotel, Washington, D. C.

NATIONAL LEAGUE FOR NURSING, Biennial Convention, *April 10-14*, Cleveland, Ohio.

GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, Annual Meeting, *April 13-16*, Hotel Berkeley Cartaret, Asbury Park, N. J.

AMERICAN ACADEMY OF GENERAL PRACTICE, Annual Scientific Assembly, *April 17-20*, Miami, Fla. (Inq. Mac F. Cahal, Volker Blvd. at Brookside, Kansas City 12, Mo.)

AMERICAN NURSES' ASSOCIATION, 12th Quadrennial Congress, *April 17-22*, Melbourne, Australia. (Inq. 10 Columbus Circle, New York City 19.)

SOCIETY OF MEDICAL PSYCHOANALYSTS, Academic Lecture, *April 19*, Medical College, New York City.

ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOANALYSIS, Annual Meeting, *April 26*, Karen Horney Clinic Bldg., 329 E. 62nd St., New York City.

AMERICAN PSYCHOSOMATIC SOCIETY, Annual Meeting, *April 28-30*, Atlantic City, N. J. (Inq. 265 Nassau Rd., Roosevelt, N. Y.)

MENTAL HEALTH WEEK, *April 30-May 6*

Joint Commission Report Theme for 13th Institute

The main theme for the 13th Mental Hospital Institute, to be held October 16 through 19, 1961, at the Hotel Sheraton-Fontenelle, Omaha, Nebraska, will be "New Perspectives on Mental Patient Care—A Consideration of the Report of the Joint Commission on Mental Illness and Health."

In accordance with the wishes expressed by those who answered the Committee's questionnaire, the Institute will follow a similar pattern to that of the Salt Lake City meeting. It will open with a keynote address, followed by a number of small-group discussions on specific subtopics related to the main theme. A panel discussion at the final afternoon session will deal with a particular phase of the Joint Commission Report. One full afternoon will be devoted to simultaneous sessions on special-interest topics.

The Report is to be published in the Spring and copies will be made available, at a special discount, to all registrants; copies can be sent out at the time of registration or bought at the Institute.

Groups wishing to hold special pre-Institute meetings on Sunday and Monday, October 15 and 16, in conjunction with the Institute, are requested to contact Mrs. Phyllis Woodward as early as possible.

Serving with Alfred H. Stanton, M.D., Chairman of the Program Committee, are James E. Gilbert, M.D., Aberdeen, S. D.; John P. Lambert, M.D., Katonah, N. Y.; John J. Blasko, M.D., Washington, D. C.; and Mr. Joseph Greco, St. Louis, Mo.

Found

A rosary, inscribed Roma, and contained in a small black leather pouch, was found near the Alpine Lodge, Brighton Canyon, Utah, on the night of the Institute barbecue. To claim your possession, write to the A.P.A. Mental Hospital Services, 1700 18th Street, N.W., Washington 9, D. C.

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PEOPLE & PLACES

CANADA: **Dr. C. H. Pottle,** former superintendent of the Hospital for Mental and Nervous Diseases in St. John's, Newfoundland, was recently appointed to the newly created post of provincial director of Mental Health Services. Succeeding Dr. Pottle at the Hospital for Mental and Nervous Diseases is **Dr. J. Frazier Walsh** who, for the past six years, has been assistant superintendent.

Dr. Morgan Martin is the new chief of the Mental Health Division, Department of National Health and Welfare, Ottawa.

CALIFORNIA: On January 1, **Dr. Elmer F. Galioni** took office as deputy director of hospital medical services for the Department of Mental Hygiene, Sacramento. Prior to this appointment, Dr. Galioni was associate superintendent of Stockton State Hospital.

Dr. R. S. Rood, former superintendent and medical director of Atascadero State Hospital, has joined the staff of Stockton State Hospital. **Dr. Louis R. Nash,** the associate superintendent at Camarillo, will assume the interim superintendency at Atascadero.

Dr. Robert J. Spratt, former director of the Montana State Department of Mental Hygiene, recently became associate superintendent of Mendocino State Hospital.

HERE & THERE: **Dr. Samuel C. Kaim** has been named chief of psychiatric research for the Veterans Administration and will be attached to the VA Central Office in Washington, D. C.

Dr. R. C. Steck, superintendent of Anna State Hospital, Illinois, has received the Distinguished Service Award from the Southern Illinois Chapter of the American Society for Public Administration.

Dr. Arthur H. Ruggles, retired physician-in-chief and superintendent of Butler Hospital, Providence, R. I., died recently in Boston, Mass. Dr. Ruggles was president of the A.P.A. from 1942 to 1943.

Dr. Seymour S. Kety has been appointed to head up the department of psychiatry at Johns Hopkins University School of Medicine and its hospital in Baltimore, Md. Dr. Kety, former chief of the laboratory of clinical science at NIMH, succeeds Dr. John C. Whitehorn who retired on June 30.

The Problem of the Incontinent Patient in a crowded ward

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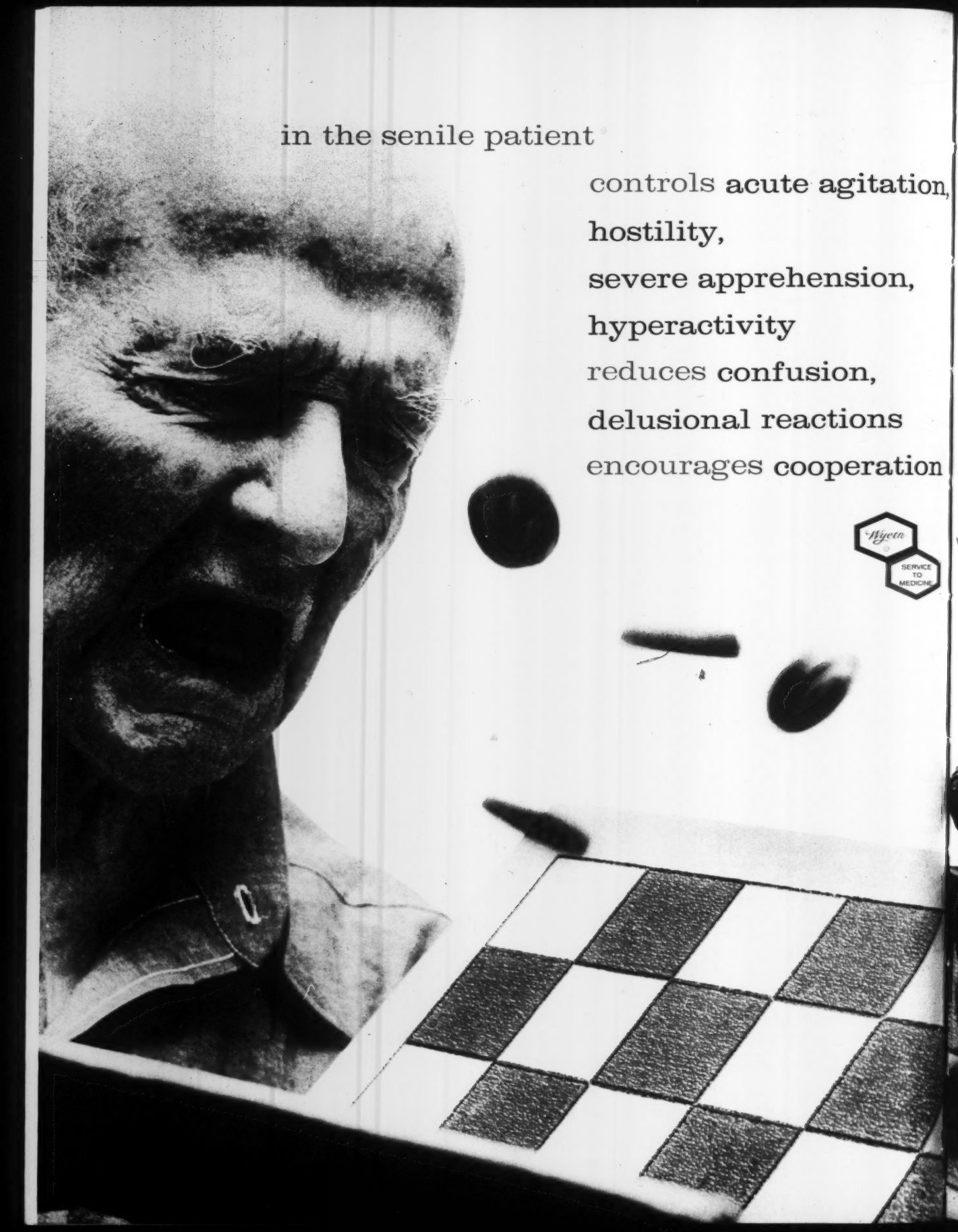
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SPARINE effectively controls central nervous system excitation, allays apprehension and anxiety, calms the agitated patient and is a useful adjunct to the management of mental and emotional disturbances. Both acute and chronic psychiatric illnesses respond to SPARINE therapy. SPARINE has been found to be useful in the management of nausea and vomiting of either central nervous system or gastric reflex origin. SPARINE effectively facilitates the action of analgesics and central nervous system depressants. It has been used as an adjunct to surgical sedation, allaying apprehension and reducing the dosage requirements for narcotics, analgesics and sedatives. SPARINE may be used as an aid in diagnostic and therapeutic regimens. Such nonspecific symptoms as anxiety, pain, vomiting, nausea and hiccups frequently make more difficult both diagnosis and therapy of organic disease. SPARINE allays such symptoms without masking physical, neurological or laboratory findings.

DIRECTIONS. For maximal therapeutic benefit the amount, route of administration and frequency of dose should be governed by the severity of the condition treated and the response of the patient. Oral administration should be used whenever possible; parenteral administration should be reserved for uncooperative patients or when nausea and vomiting interfere with oral administration. SPARINE *when used intravenously should not exceed a concentration of 25 mg. per cc.: injection should be given slowly.* Dilute 50 mg. per cc. concentration with equivalent volume of physiological saline before I.V. use. Avoid injection around or into the wall of the vein.

In the management of agitated patients. SPARINE should be given I.V. in initial doses of 50 to 150 mg. If the desired calming effect is not apparent within 5 to 10 minutes, additional doses up to a total of 300 mg. may be given. Once the desired effect is obtained, SPARINE may then be given I.M. or orally in maintenance doses of 10 to 200 mg. at 4 to 6 hour intervals. *In less severe disturbances*, initial oral therapy may be satisfactory. When tablet medication is unsuitable or refused, SPARINE Syrup may be used.

Medical uses. Antiemetic.
Usual dose is 25 to 50 mg. repeated at 4 to 6 hour intervals. When oral route is not feasible, 50 mg. I.V. or I.M. will usually control the symptom, but oral medication should be initiated as soon as feasible.

In the management of pain associated with malignancy or chronic disease, SPARINE may be administered orally or I.M. in 25 to 50 mg. doses repeated at 4 to 6 hour intervals to allow for reduced dosage of analgesics. *In medical emergencies*, to allay apprehension and facilitate diagnosis or therapy, SPARINE should be given I.V., I.M. or orally in 50 to 200 mg. doses. See direction circular for details.

PRECAUTIONS. Although rare, drowsiness, dizziness and transitory postural hypotension may occur. If a vasopressor drug is indicated, norepinephrine is recommended since SPARINE reverses the effect of epinephrine. Agranulocytosis has been reported in only 18 cases in about 3½ million patients. If, however, signs of cellular depression—sore throat, fever, malaise—become evident, discontinue SPARINE, check white blood cell count, and initiate antibiotic and other suitable therapy if indicated. Seizures, reported as occurring during SPARINE therapy, occur usually with rapid large increases in dose and at a daily dosage above 1 Gm. Caution must be exercised when administering SPARINE to patients with a history of epilepsy. Avoid perivascular extravasation or intra-arterial injection, as severe chemical irritation or inflammatory response may result. Because of its facilitating action on analgesics and central nervous system depressants, give them only in reduced dosage with SPARINE. Do not use in comatose states due to central nervous system depressants (alcohol, barbiturates, opiates, etc.). Use with caution in patients with cerebral arteriosclerosis, coronary heart disease, or other conditions where a drop in blood pressure may be undesirable.

For further information on prescribing and administering SPARINE, *see descriptive literature, available on request.*

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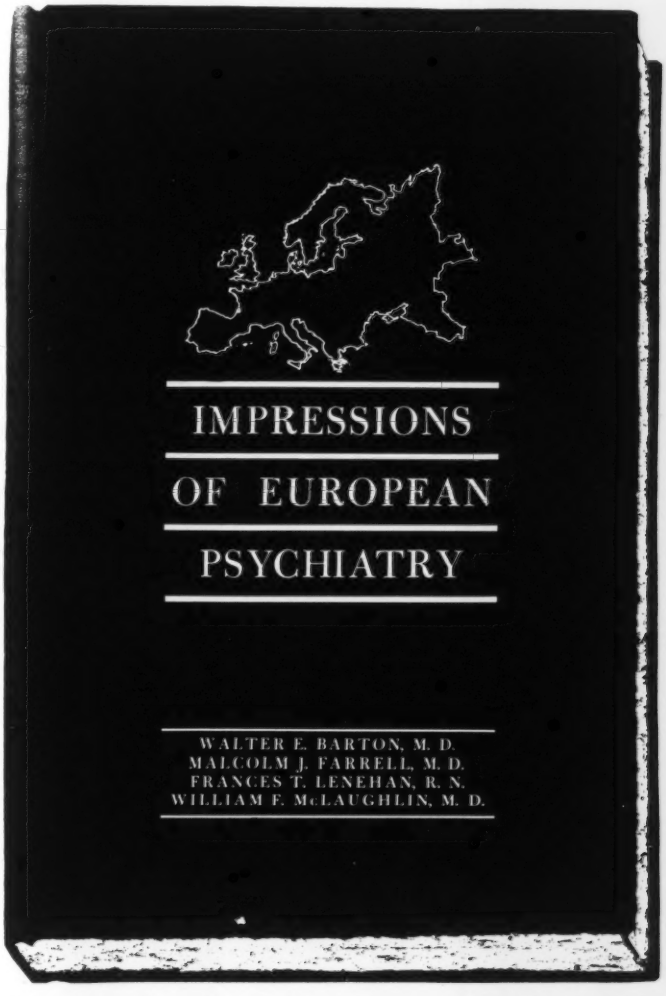

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